

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1

04549

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04542

1. DECEASED-NAME (Type or print) First Middle Last <b>Anna Virginia Albakri</b>			2a. DATE OF DEATH <b>3 Month 5 Day 69 Year</b>		2b. HOUR <b>11:00 PM</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>Oct. 11, 1903</b>		6. AGE (In years ( <b>65</b> birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Washington</b>		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5 Garrett St.</b>
14. FATHER'S NAME First Middle Last <b>Alwin Doering</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Doering</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mustafa Albakri Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>393X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-4-69</b> , 19 <b>69</b> , to <b>3-5-69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-5-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. R. Landry, Jr.</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-7-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>E. R. Landry, Jr.</b>		22e. ADDRESS <b>300 Co. Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>3-8-69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 10 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

04242

Name: Virginia  
 Date: 11/10/52  
 Address: Washington  
 Telephone: 2-1000  
 Subject: [illegible]  
 Remarks: [illegible]

[illegible]  
 [illegible]  
 [illegible]

[illegible]  
 [illegible]  
 [illegible]

[illegible]  
 [illegible]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04550										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04543	
CERTIFICATE OF DEATH																					
1. DECEASED NAME (Type & print) First Middle Last <b>ANN MARGARET (Margie) ARMSTRONG</b>										2a. DATE OF DEATH Month Day Year <b>March 25 1969</b>										2b. HOUR <b>3:20 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>7/13/1885</b>				6. AGE (In years last birthday) <b>83</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <b>Greencastle, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Washington</b>				Md.									
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housekeeper</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Greencastle</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>52 E. Madison St.</b>													
14. FATHER'S NAME First Middle Last <b>William Worley</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Rachel Johnson</b>																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>176-34-3336</b>		17. INFORMANT Address <b>Mrs. Gene Ingalls - Greencastle</b>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4124</b> IMMEDIATE CAUSE (a) <b>Cardiac dilatation and insufficiency.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b>  <b>15 or 20 years.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>1945</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <b>1945</b> , 19____, to <b>3-25-69</b> , 19____, that (I) (we) last saw the deceased alive on <b>3-24-69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <b>William C. Brewer, M.D.</b>										22c. DATE SIGNED <b>3-25-69</b>		22d. PHYSICIAN'S NAME (Type) <b>William C. Brewer, M.D.</b>									
22e. ADDRESS <b>359 E. Baltimore St., Greencastle, Pa.</b>																					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>				23b. DATE <b>3/28/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Greencastle, Pa.</b>											
24. FUNERAL DIRECTOR <b>A. E. Munnich - Greencastle, Pa.</b>				25. RECEIVED BY REGISTRAR <b>MAR 28 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>													

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04551

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04544

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>First ERNEST Middle (None) Last ASHBY</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1969</b>			2b. HOUR <b>3:35 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>6-3-1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Care Center</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STAT Maryland</b>			13b. COUNTY <b>GARRETT</b>		13c. CITY OR TOWN <b>Oakland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>719 E Oak St. Oakland</b>	
14. FATHER'S NAME <b>First I FRANK Middle Last ASHBY</b>			15. MOTHER'S MAIDEN NAME <b>First Rachel Middle Olive Last Harvey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213-01-5650</b>		17. INFORMANT Address <b>Beessie Florence Ashby</b> Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of Right Coronary Artery</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Within 24 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Multiple Pulmonary Emboli, Cerebrovascular Accident</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>March 18, 1969</b> , to <b>March 22, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Joel Porciunoula M.D.</b>			22c. PHYSICIAN'S NAME (Type) <b>FEU. Porciunoula</b>			22d. ADDRESS <b>Western Maryland State Hospital</b>		22e. DATE SIGNED <b>March 22, 1969</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/25/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Terra Alta, Preston, W. Va.</b>			
24. FUNERAL DIRECTOR <b>John O. Durst</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 26 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

12521

WILLIAM H. H. H. H.

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04552

## CERTIFICATE OF DEATH

04545

1. DECEASED-NAME (Type or print)		First LENA	Middle GLENORA	Last BARKDOLL	2a. DATE OF DEATH MARCH Month 28 Day 1969		2b. HOUR 30 P. M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3/9/1913		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital add name of home) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done adding major type of occupation, even if not regular) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. CITY OR TOWN WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 W. IRVIN AVE.	
14. FATHER'S NAME First HARRY		Middle R.		Last POWELL		15. MOTHER'S MAIDEN NAME First ALMA		Middle E.	
Last TRUMPOWER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (known) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 219-36-3761		17. INFORMANT MRS. ALMA E. POWELL		HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 203X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1969</u> , to <u>March 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>					22c. DATE SIGNED 3/31/69		22d. PHYSICIAN'S NAME (Type) Richard E. Smith, M.D.		
22e. ADDRESS 998 Potomac Avenue-Hagerstown, Md.									
23a. BURIAL, CREMATION, or other disposition BURNED		23b. DATE 3/31/69		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR <u>W. J. Norment, Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		

TO HOSPITAL OR TENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04553		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04546	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>Harry Anthony Bauer, Sr.</b>				2a. DATE OF DEATH <b>3</b> Month <b>23</b> Day <b>69</b> Year		2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>6-12-1912</b>		6. AGE (In years last birthday) <b>56</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cab Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wash. Williamsport</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>Henry Bauer</b>		15. MOTHER'S MAIDEN NAME <b>Antionette Platz</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>091-09-6181</b>		17. INFORMANT <b>Mrs. Hazel Bauer Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio sclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <b>19</b> HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 14</b> , 19 <b>67</b> , to <b>Nov 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov 14</b> , 19 <b>67</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edwin J. Hoach</b> DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>3/24/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Edwin J. Hoach</b>				22e. ADDRESS <b>Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3-26-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>MAR 26 1969</b>							

00553

01-01-1955

Army, Infantry, 1st Div., 1st Bn., 1st Co.

1-11-1955

1st Bn., 1st Co.

1st Bn., 1st Co.

USA

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

1st Bn., 1st Co., 1st Div., 1st Bn., 1st Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1

04554

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04547

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>CARL VINCENT BLACK</b>			2a. DATE OF DEATH Month Day Year <b>March 6 1969</b>			2b. HOUR <b>2.10</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 13 1893</b>		6. AGE (In years lost birthday) <b>75</b> YRS		7. UNDER YEAR MONTHS DAYS <b>12</b> MONTHS <b>1</b> DAY		8. UNDER 24 HRS HOURS MIN <b>10</b> HOURS <b>10</b> MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>					
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Williamsport Sanatorium</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INS DE CITY, M.I.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>720 West Franklin St</b>			
14. FATHER'S NAME First Middle Last <b>David J. Black</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Sallie Vincent</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>220-09-7753</b>		17. INFORMANT Address <b>Claude D. Johnson 720 W. Franklin St Hagerstown Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). noting the underlying cause (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>15 yrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetic Hyperglycemia</b>											
19a. DATE OF OPERATION <b>3-7-69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>3-7-69</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <b>While at work</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>3-7-69</b>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) <b>3-7-69</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>Williamsport Md.</b>							
22a. I certify that (I) this hospital attended the deceased from <b>Jan 3-4 1964</b> to <b>3-6 1969</b> , that (II) (we) last saw the deceased alive on <b>3-4 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>M.E. Byrkit</b>		22c. DATE SIGNED <b>3-7-69</b>		22d. PHYSICIAN'S NAME (Type) <b>M.E. Byrkit</b>							
22e. ADDRESS <b>Williamsport Md.</b>											
23a. BURIAL, CREMATION, REMOVABLE (Specify) <b>Burial</b>		23b. DATE <b>3/8/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash. Co Md.</b>					
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR <b>MAR 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. [Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in every event, within 72 hours after death.

04555

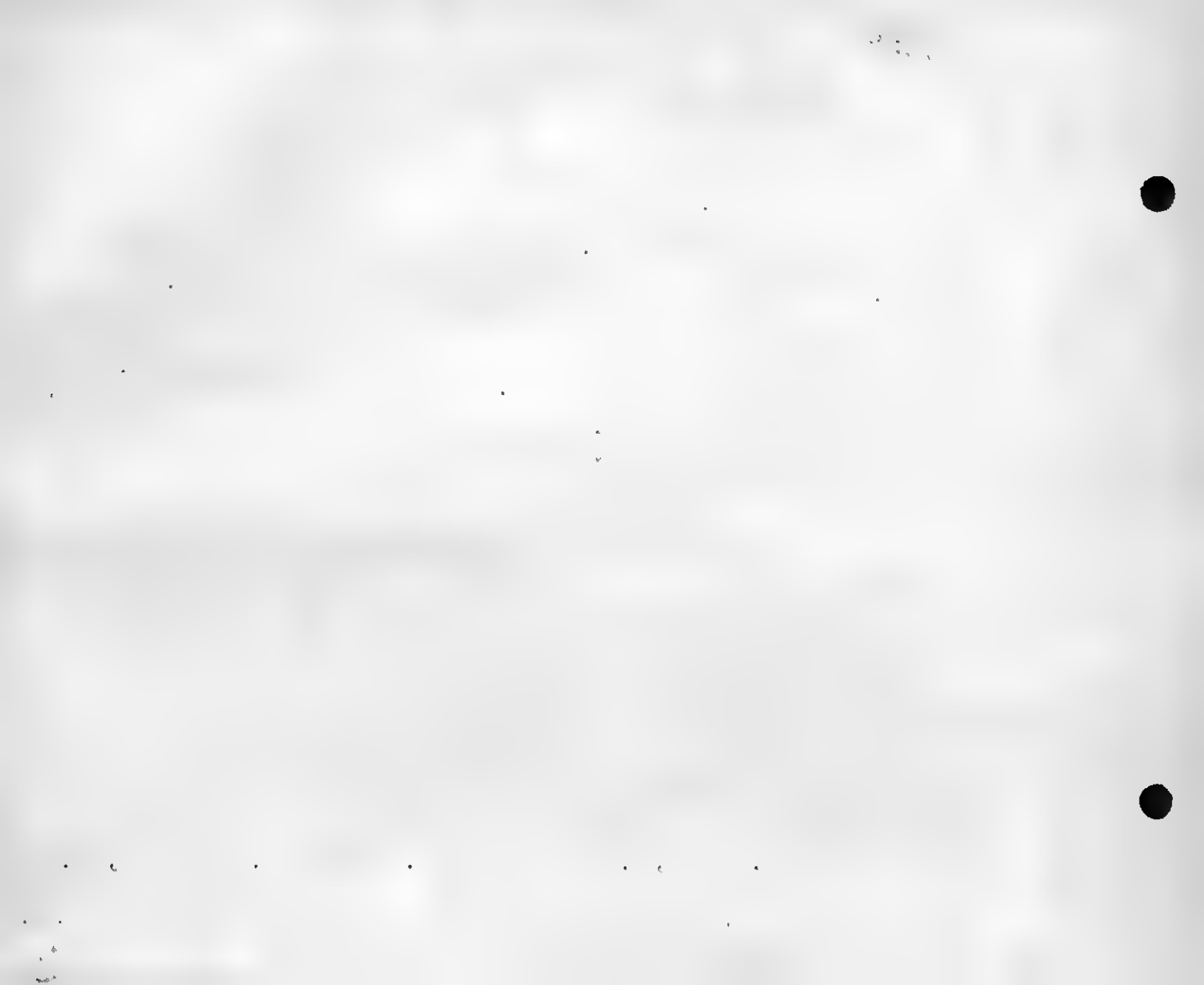
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04548

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR					
Nathan Blaine Blickenstaff						March 15 1969			3:35P M					
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			7. UNDER 1 YEAR		8. UNDER 24 HRS			
Male	White		October 5, 1913			55 YRS			MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Ohio			U.S.A.						Washington Md.					
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Rural-Williamsport			223 Bower Ave. R.F.D. 2			Folder			Foundry					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY, VILLAGE, OR SUBURB			13e. STREET AND NUMBER		
Maryland			Washington			Williamsport			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			223 Bower Ave. Williamsport RFD #2		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Edward B. Blickenstaff						Mabel Cline								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT								
No			217-10-2994			223 Bower Ave. Mrs. Loraine Blickenstaff Williamsport, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>											2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											6 years			
(b) <u>Parkinsonism</u>														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
<u>Extensive decubiti</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION								
						Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 24</u> , 19 <u>66</u> , to <u>Mar 13</u> , 19 <u>69</u> , that (I) <u>was</u> lost saw the deceased alive on <u>Mar 14</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>(did not)</u> view the body after death.														
22b. SIGNATURE						DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
<u>W. J. Layman, M.D.</u>												Mar 17 69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
William T. Layman, M.D.						301 E. Antietam St. Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			March 18, 1969		Rest Haven Cemetery			Hagerstown, Maryland Wash. Co.						
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Albert L. Leaf Williamsport, Maryland									MAR 21 1969		<u>James Judge</u>			





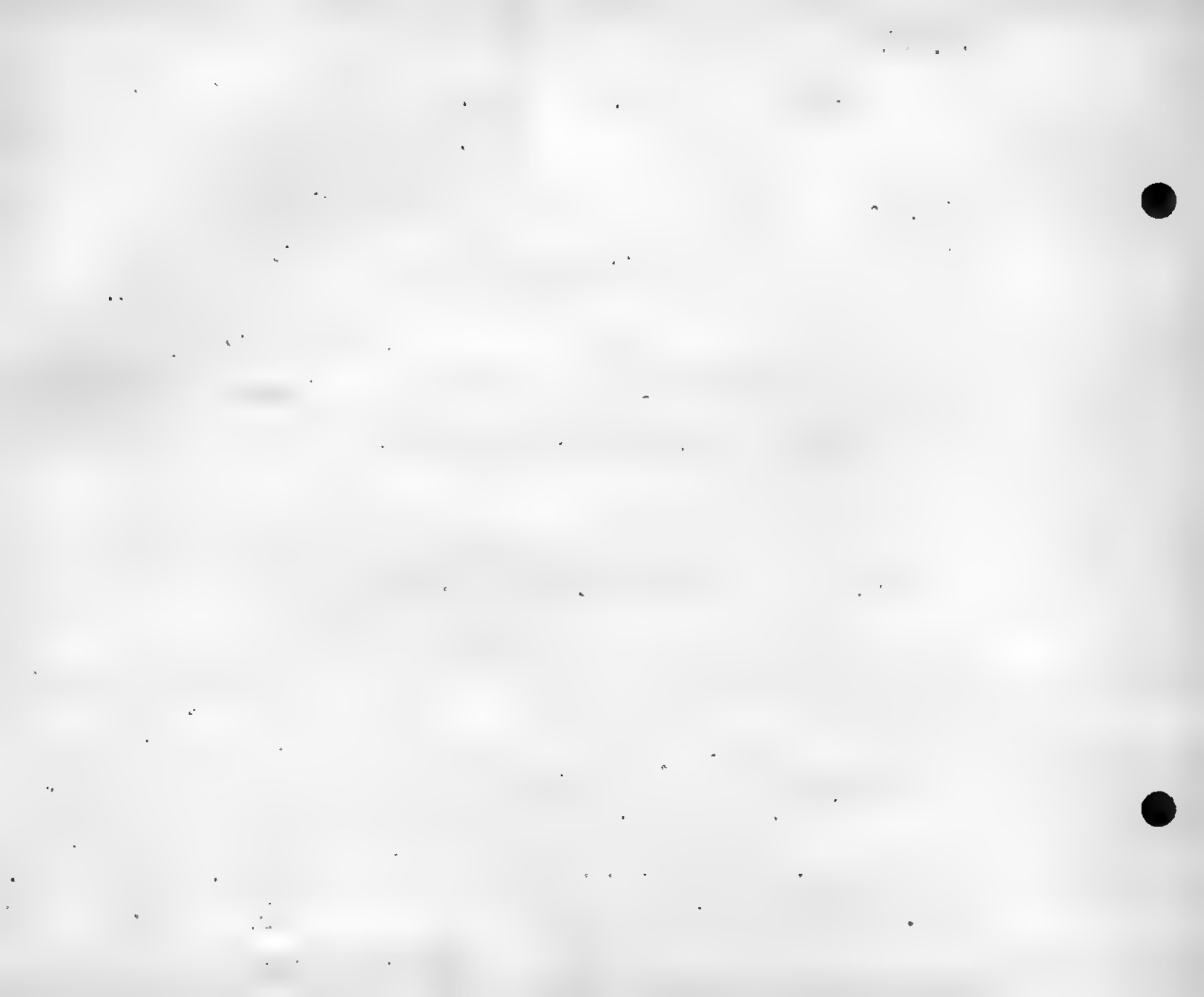




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and get 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04557		CERTIFICATE OF DEATH						04550	
1 DECEASED-NAME (Type or print)		First <b>LEONA</b>		Middle <b>MAUDE</b>		Last <b>BROWN</b>		2a DATE OF DEATH <b>March</b> Month <b>3</b> Day <b>16</b> Year <b>1969</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>2/1/90</b>		6 AGE (In years last birthday) <b>79</b> YRS		2b HOUR <b>7:43</b> PM	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>409 McDowell Ave.</b>	
14. FATHER'S NAME First <b>Scott</b>		Middle <b>Pryor</b>		Last <b>Pryor</b>		15. MOTHER'S MAIDEN NAME First <b>Carrie</b>		Middle <b>REDMOND</b> Last <b>Pryor</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <b>213-48-8980</b>		17. INFORMANT Address <b>MR. DONALD C. BROWN HAGERSTOWN MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b>									<b>unknown</b>
4121 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Nephrosclerosis with uremia; Diabetes mellitus, mild</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <b>February 16, 1969</b> , to <b>March 3, 1969</b> , that (I) (we) lost the deceased alive on <b>March 3, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Fe U Porciuncula MD</b>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/3/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Fe U. Porciuncula, M.D.</b>		22e. ADDRESS <b>Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/6/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Hagerstown Wash. Md</b>			
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE MAR 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18; Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

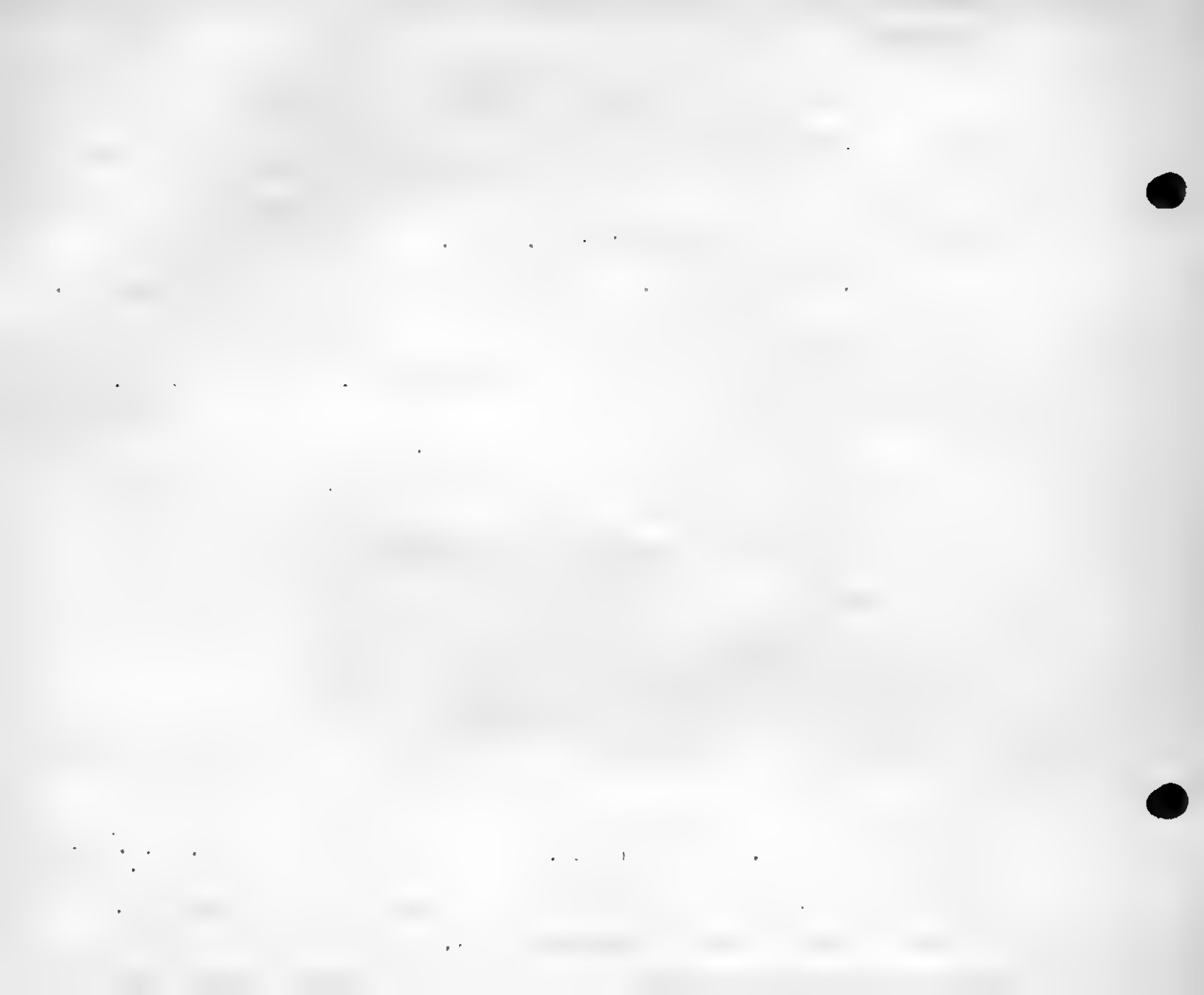
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04558

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04551

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
James Christopher Brugh						Month Day Year			9 1/2 1969		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
male	white	8-3-56	12 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			9 1/2 1969
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH			
Maryland		USA		WIDOWED		DIVORCED		Washington Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a JSJA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hosp.			none					
13a JSJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.			Wash.		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1629 Woodcrest Rd.		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Donald Brugh			Lenora Aubele								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
no			none			Donald Brugh, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u>										18 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>with Marked Pulmonary Edema</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
			HOUR A.M. 1:30 P.M.			3-1-19 69 choked on vomitus -					
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		1629 Woodcrest		Hagerstown		Wash		Md	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EDWARD W. DITTO, III, M.D.				CHIEF MEDICAL EXAMINER		22b DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER		3/3/69			
						DEPUTY MEDICAL EXAMINER		217-W. Wash. St.			
						ADDRESS (Street, city, town, or county)		HAGERSTOWN, MARYLAND			
23a BURIAL, CREMATION		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		3-5-69		Rose Hill Cemetery		Hagerstown, Md.					
24 FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Minnich Funeral Home, Hagerstown, Md.						DATE MAR 6 1969		William J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR 14  
45M - 1969

04559		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04552	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First LLOYD		Middle EVERETT		Last BURGAN	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 7/21/1905		2a. DATE OF DEATH MARCH 25 Day 1969 Year	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work life) RETIRED FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 920 LANVALE ST.		14 FATHER'S NAME First EVERETT		Middle SAMUEL		Last BURGAN	
15 MOTHER'S MAIDEN NAME First HENRIETTA		Middle ARDINGER		Last ARDINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 217-10-2998		17 INFORMANT MRS. MARGUERITE D. BURGAN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gangrene of rt. leg arterio occlusion of rt. DUE TO, OR AS A CONSEQUENCE OF femoral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days 8 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 21, 1969, to March 25, 1969, that (I) (we) last saw the deceased alive on March 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. E.W. Ditto, Jr.		DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED March 26, 1969	
22d. PHYSICIAN'S NAME (Type) Dr. E.W. Ditto, Jr.		22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL CREMATION BURIED		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) SHARPSBURG WASH. MD.	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04560

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04553

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>ANNIE TIRZAH BURNER</b>			2a. DATE OF DEATH Month <b>31</b> Day <b>69</b> Year <b>1969</b>		2b. HOUR <b>5:30 a.m.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>JUNE 30, 1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>TASMANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>WASHINGTON</b> Md.		
10. CITY OR TOWN OF DEATH <b>MAUGANSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMNONITE HOME</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>WASHINGTON</b>	13c. CITY OR TOWN <b>HAJERSTOWN</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>2304 ROCKCLIFFE DR.</b>	
14. FATHER'S NAME First Middle Last <b>JOSEPH JOHNS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ANN ANDREW</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>530-01-4706J</b>		17. INFORMANT <b>2304 Address: ROCKCLIFFE DR. MR. JORDON BURNER HAJERSTOWN, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>400X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dehydration and Malnutrition</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (his hospital) attended the deceased from <b>May</b> , 19 <b>61</b> , to <b>March 31</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 27</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Howard N. Weeks, M.D.</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/31/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>HOWARD N. WEEKS, M.D.</b>		22e. ADDRESS <b>580 NORTHERN A.E., HAJERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/3/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESLEY CHAPEL CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>COLUMBUS, FRANKLIN, OHIO</b>		25a. REC'D BY REGISTRAR <b>DATE APR 7 1969</b>			
24. FUNERAL DIRECTOR <i>Charles Rouger</i>		ADDRESS <b>HAJERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





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VR 115  
30M REV

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR a M				
HARVEY		EDGAR	CANTNER	MARCH 10 69		2:20					
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.		
MALE	WHITE		JULY 15, 1894		74 YRS.						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				WASHINGTON				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		WASHINGTON COUNTY HOSP.		RETIRED SERVICE MAN		U.S.A. ARMY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - Y.N.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON		HAGERSTOWN				ROUTE #5			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
ALBERT				CANTNER	FLORENCE				SAUNDERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
YES		WW I		219-54-0993		MRS. LOUISE CANTNER		ROUTE #5 HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4 Hemorrhage related to atherosclerosis				Thrombosis of right middle cerebral artery		cerebral arteriosclerosis					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
aortic atherosclerosis heart disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from May 27, 1966, to March 4, 1969, that (I) (we) last saw the deceased alive on March 4, 1969, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Edson B. Moody		3/11/69		EDSON B. MOODY, M.D.		363 CLEVELAND AVE., HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		3/13/69		ROSE HILL CEMETERY		HAGERSTOWN, WASHINGTON, MD.					
24. FUNERAL DIRECTOR		ADDRESS		25. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles R. Rouser		HAGERSTOWN, MARYLAND		MAR 14 1969							



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04555	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
ROBERT CHARLES ADAM CARBAUGH SR.								Month 3 Day 28 Year 1969		7 a M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		2c DATE PRONOUNCED DEAD		2d HOUR	
MALE	WHITE	SEPTEMBER 2, 1911		57 YRS		MONTHS DAYS HOURS MIN.		Month March Day 28 Year 1969		9:30 AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.		WIDOWED		WASHINGTON					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN				121 CLINTON AVE.				SELT METAL ASSEMBLY		FAIRCHILD HILLS	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN		13d STREET AND NUMBER	
MARYLAND				WASHINGTON				HAGERSTOWN		121 CLINTON AVENUE	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
CLINTON A CARBAUGH				LILY M TSCHOPP							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT			
No				214-10-1442				MRS. HELEN M CARBAUGH			
								ADDRESS 121 CLINTON A E. HAGERSTOWN, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion										Hours	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) Arteriosclerotic coronary heart disease Years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES NO X			
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A M P M 19							
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy, Inspection X, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				3/28/69			
HOWARD N. WORKS, M.D.				DEPUTY MEDICAL EXAMINER X				Washington			
580 NORTHERN A.E., HAGERSTOWN, MD.				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				3/31/69				MT OLIVET CEMETERY			
24 FUNERAL DIRECTOR				23d LOCATION (City or town) (County) (State)				23e REC'D BY REGISTRAR			
Charles R. Rouse				FREDERICK, FREDERICK, MARYLAND				DATE APR 1 1969			
HAGERSTOWN, MARYLAND				23f REGISTRAR'S SIGNATURE				Charles R. Rouse			





# FOR STATE HEALTH DEPT.

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18-222a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH  
4-8-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04563

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04556

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Ralph			Melvin			Clem			Month Day Year		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
male			white			11-23-1913			55 YRS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 COUNTY OF DEATH		
J. Va.			USA			WIDOWED			Washington		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hosp.			Carpenter			Building		
13a U.S.A. RESIDENCE (Where deceased lived, if not in hospital admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER		
Md.			Washington			Hagerstown			164 W. Washington St.		
14 FATHER'S NAME			15 MOTHER'S M.A.DEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.		
George			Clem			yes			232-10-3804		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Florence			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7123</u> <u>Pulmonary Focal hemorrhages in mid brain &amp; adjacent to mammillary bodies,</u>						20 AUTOPSY?		
??			(b) <u>Atherosclerosis of aorta, coronary arteries, &amp; cerebral arteries, minimal</u>						14 hrs.		
			(c) <u>10-15 yrs</u>								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
			<u>Pulmonary emphysema</u>								
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			P.M. 19								
21d INJURY OCCURRED WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town		
NOT WHILE AT WORK									County		
									State		
22a I certify that I took charge of the remains described above, held on death resulted from			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			3-14-69					
EDWARD W. DITTO, III, M.D.			DEPUTY MEDICAL EXAMINER			217 W. WASHINGTON ST.					
			ADDRESS (Street, city, town, or county)			HAGERSTOWN, MARYLAND					
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		
burial			3-17-69			Edge Hill Cemetery			Jefferson Co.		
24 FUNERAL DIRECTOR			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
E. Guy Davis			DATE			20 1969					
for: Melvin T. Strider Co., Charles Town, W. Va.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

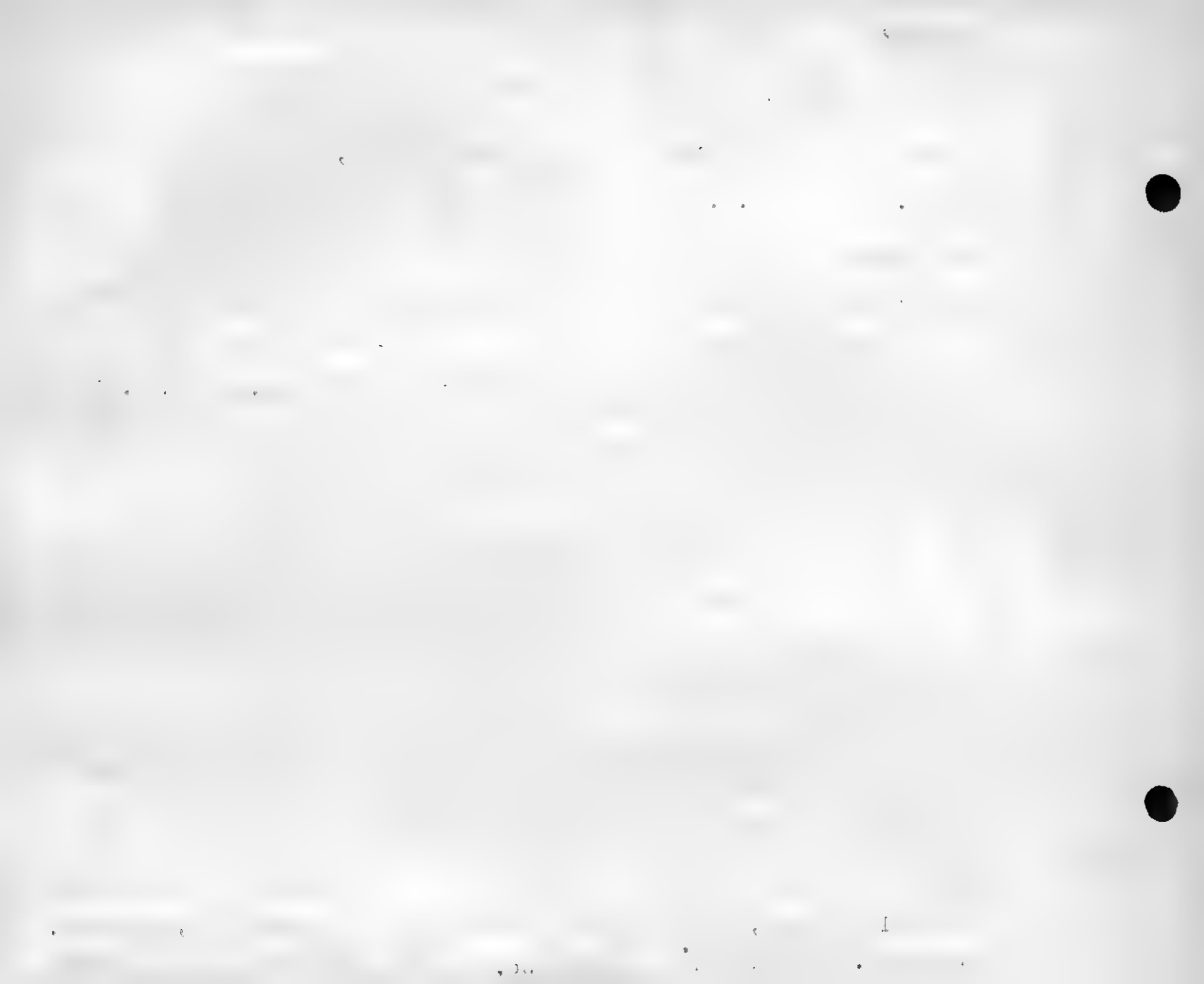
04564

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04557

1 DECEASED NAME (Type or print)		First <b>CHARLES</b>	Middle <b>IRVIN</b>	Last <b>CRAMER</b>	2a DATE OF DEATH Month Day Year <b>March 21, 1969</b>			2b HOJR 10:45 70A.M.	
3 SEX <b>Male</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>November 22,</b>		6 AGE (In years last birthday) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Washington</b>			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Garlock Nursing Home</b>		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) <b>Watchman</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admn assign) STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>71 Madison Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Charles Cramer</b>				15 MOTHER'S MA DEN NAME First Middle Last <b>Sarah Jones</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>220056106</b>		17 INFORMANT Address <b>Harvey Winters Hagerstown R.#1</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Cardio-Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>approx. 4-69</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Diabetes Mellitus</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that (I) (this hospital) attended the deceased from <b>Feb 28</b> , 19 <b>69</b> , to <b>March 21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 20</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sidney Hoveston MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>3-22-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>SIDNEY HOVESTON</b>				22e. ADDRESS <b>FUNK STAN MD.</b>					
23a BURLIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>March, 24, 1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Hagerstown, Maryland.</b>			
24 FUNERAL DIRECTOR <b>Hagerstown, Md.</b>				ADDRESS <b>Andrew K. Coffman Funeral Home Inc.</b>		25a REC'D BY REGISTRAR <b>MAR 26 1969</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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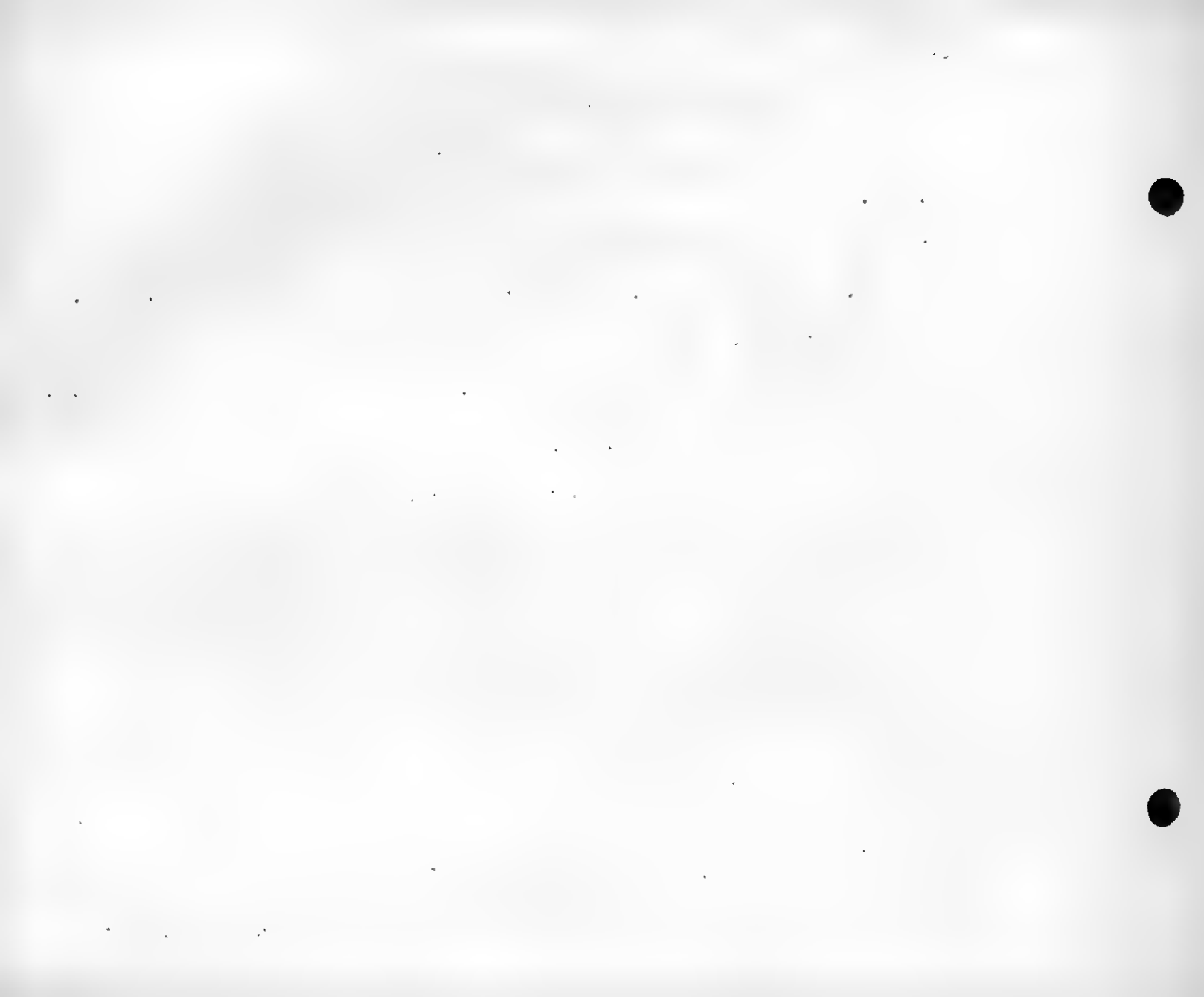
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04565		CERTIFICATE OF DEATH						04558			
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
HARRY GARFIELD DELAUTER						March 27, 1969			12:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		
male		Caucasian		Sept. 17, 1882			86 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. UNDER 24 HRS		
Fred. Co. Md.		U.S.A.				Washington			Mo		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hospital			Ret. Farmer			Ge. Farm.		
13a. USUAL RES DENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Frederick		Myersville				Route # 1		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
David Delauter			Louise Hoover Delauter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no			215-48-9279		Harry D. Delauter, Rt. 1 Myersville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>										1 week	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										10 years	
(b) <u>Arteriosclerotic cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9-19-1966, to 3-27-1969, that (I) (we) last saw the deceased alive on 3-26-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles F. Hess						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-28-69			
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.						22e. ADDRESS Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Mar. 29, 1969		Grossnickle's			Rt. Myersville Fred. Co. Md.			
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.						25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE			



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04566										
CERTIFICATE OF DEATH										
04559										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lucy Elizabeth Douglas						3 Month 23 Day 69 Year		517 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		
female		white		11-30-1876		92 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
W. Va.		USA				Washington		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Williamsport			Williamsport Sanitarium			Seamstress				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		127 Roessner Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George W. Fauver			Rosie Ainsworth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No					Mrs. Lillian Souders, Hagerstown, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										
(b) <u>Cerebral arterio-sclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>65</u> , to <u>May 23</u> , 19 <u>69</u> , that (I) <u>not</u> last saw the deceased alive on <u>March 10</u> , 19 <u>69</u> , and that in <u>my</u> <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>not</u> <u>did</u> (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<u>Sidney Rockefeller</u>								3-25-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
SIDNEY ROCKEFELTER		FV HAGERSTOWN MD.								
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-26-69		Greenlawn Cemetery		Williamsport Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.				MAR 27 1969		<u>Charles Judge</u>				





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VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
04567		CERTIFICATE OF DEATH						04560						
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
SYLVESTER			NORMAN		ECTON				Month MARCH		Day 1			
3 SEX			4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.		
Male			White		June 2 1913			55 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Maryland			U.S.A.						Washington					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown				Washington County Hospital				Laborer				Victory Products		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY L.M.T.S?		13e STREET AND NUMBER				
Maryland				Washington		Sharpsburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Antietam Furnace				
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last		
Norman			Lester		Jamison					Sarah			Jamison	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO.		17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)				
No				219-12-2313		Mr. Norman L. Ecton				Antietam Furnace Sharpsburg Md. RFD #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) <u>Atherosclerotic heart disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
① Post staton reaction abdominal aortic aneurysm ② Pulmonary infarction														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2/21/69			Abdominal aortic aneurysm			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from <u>18 February, 1969</u> , to <u>1 March, 1969</u> , that (I) (we) last saw the deceased alive on <u>18 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MEO DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
John R. Marsh M.D.										27 March 1969				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
John R. Marsh M.D.						Hagerstown, Maryland.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			March 5-69			Mt. View Cemetery			Sharpsburg Wash.. Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Albert L. Leaf Williamsport Md.								MAR 6 1969		James J. J. J.				



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Items 1 & 18 Film 411  
4/2/69 kk

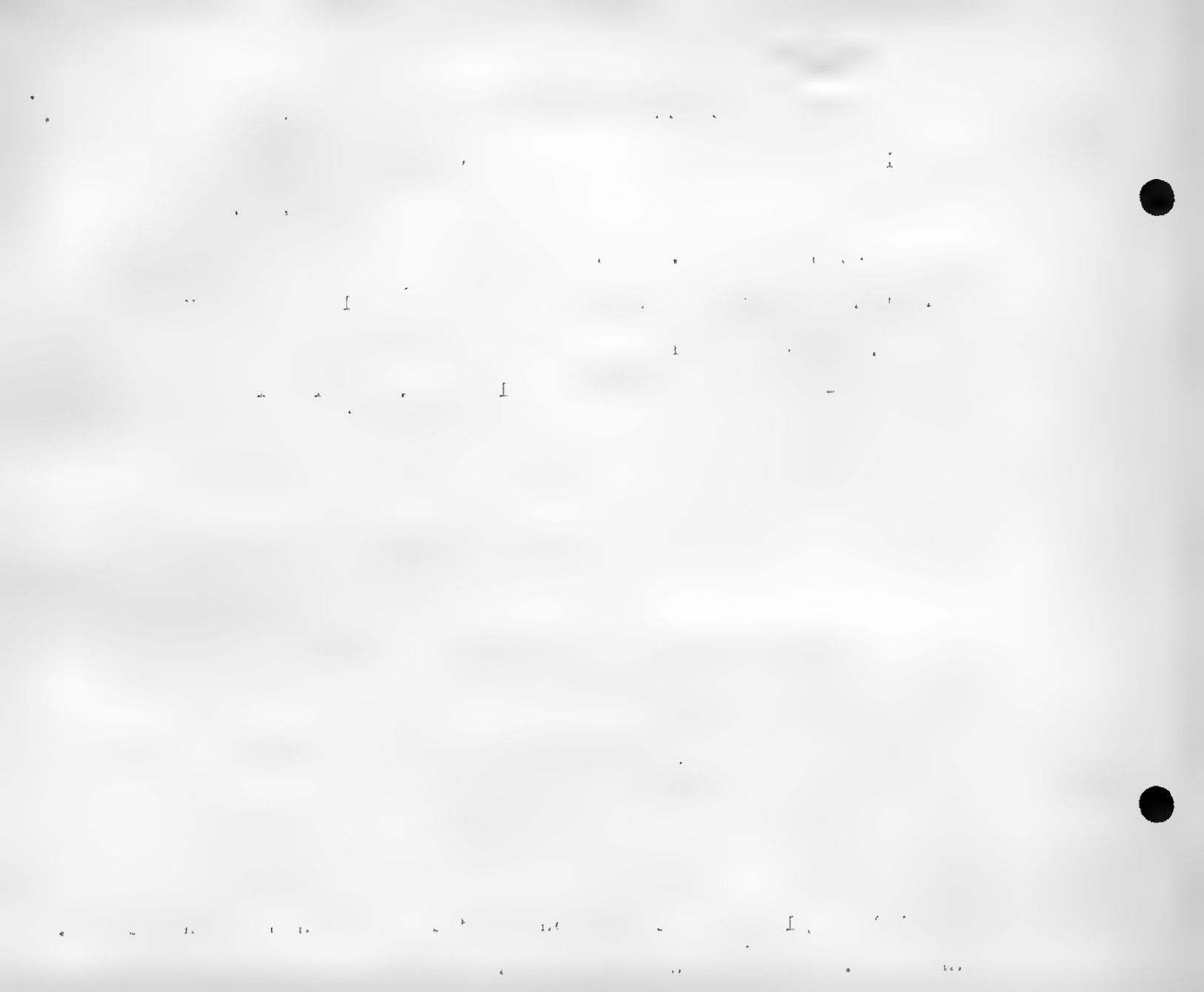
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04568

CERTIFICATE OF DEATH

04561

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P.M.	
ABBIE LEILA ESHENBAUGH					March 6 1969		6.30	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White		December 2 1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Penna	USA				Washington			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Wash. County Hospital		Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.W. 35?		13e. STREET AND NUMBER
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		106 North Ave
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
A. H orton Shields					Margaret McCoy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT		Address		
No		219-16-1073		Wilbur L. Shields		106 North Ave Hagerstown Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction & Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis, Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Yes Yes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes.		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 30 March, 1962, to 6 March, 1969, that (I) (we) last saw the deceased alive on 6 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		W.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		W. N. FENDER		22e. ADDRESS		8 March 1969		
				218 N. Potomac St., Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/10/69		Mt Lebanon Cemetery		Lebanon Lebanon Co. Pa.		
24. FUNERAL DIRECTOR		Hagerstown Md		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman		Funeral Home Inc				MAR 13 1969		



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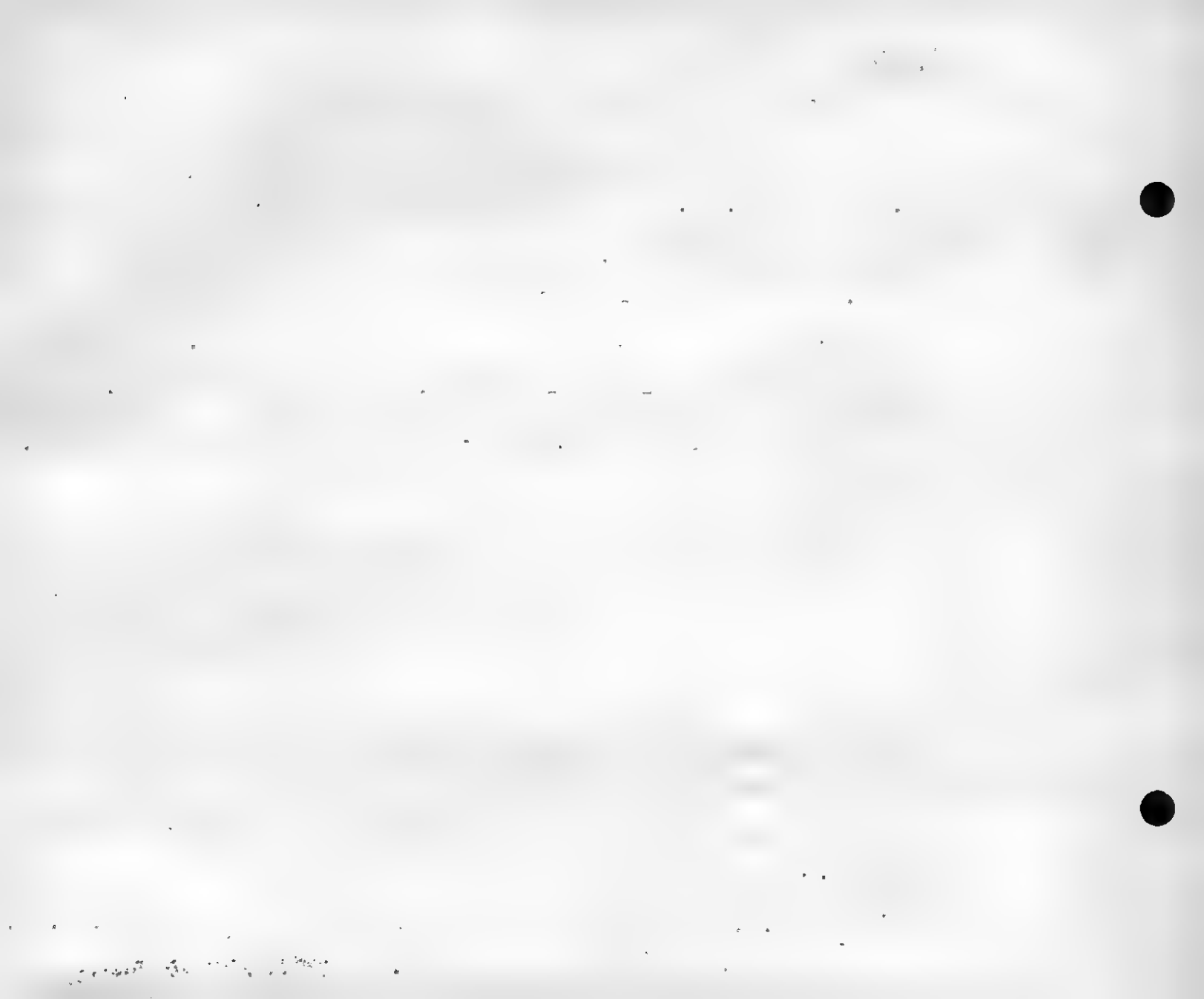
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04569

CERTIFICATE OF DEATH

04562

1. DECEASED-NAME (Type or print) First Middle Last Bertha Leah Finneyfrock			2a. DATE OF DEATH Month Day Year March 30 1969		2b. HOUR 6:55 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH 6/11/94		6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Frederick	13c. CITY OR TOWN Myersville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route # 2
14. FATHER'S NAME First Middle Last Albert Farsht		15 MOTHER'S MAIDEN NAME First Middle Last Lucy B. Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 218-30-9816-B		17. INFORMANT Address John P. Farsht, Myersville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Endometrium with pulmonary metastasis</u> 182.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 months.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>68</u> , to <u>March 30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chong Choon Han		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED March 30, 1969	
22d. PHYSICIAN'S NAME (Type) Dr. Han		22e. ADDRESS Western Maryland State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Salem United Methodist Wolfsville, Fred. Co. Md.	
24. FUNERAL DIRECTOR Paul F. Biddle		ADDRESS Myersville, Md.		25a. REC'D BY REGISTRAR APR 3 1969	
				25b. REGISTRAR'S SIGNATURE J. Charles Jones	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First <b>Effie</b>		Middle <b>Mary</b>		Last <b>Ford</b>		2a DATE OF DEATH <b>March</b> Month <b>3</b> Day <b>1969</b> Year		2b HOUR <b>10:55</b> P.M.	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>5/28/79</b>		6 AGE (In years last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.					
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. #2, Boonsboro, Md.</b>			
14. FATHER'S NAME First <b>William</b>		Middle <b>Ford</b>		Last <b>Ford</b>		15 MOTHER'S MAIDEN NAME First <b>Annie</b>		Middle <b>Kaufman</b>		Last <b>Kaufman</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>215-48-0386</b>		17. INFORMANT Address <b>Mrs. Harry Kendle, Rfd. 1, Hagerstown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the rectum</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 17, 1962</b> , to <b>March 3, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <b>Fe U. Porciuncula</b> M.D.		22c. DATE SIGNED <b>3/3/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Fe U. Porciuncula, MD</b>		22e. ADDRESS <b>Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-6-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) <b>Boonsboro, Wash. Co., Md.</b>		23e. COUNTY <b>Washington</b>		23f. STATE <b>Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr.</b>		24a. ADDRESS <b>112 N. Main St. Boonsboro, Md.</b>		24b. REC'D BY REGISTRAR <b>MAR 10 1969</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24d. DATE <b>MAR 10 1969</b>		24e. TIME <b>10:55</b>	





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04571

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04564

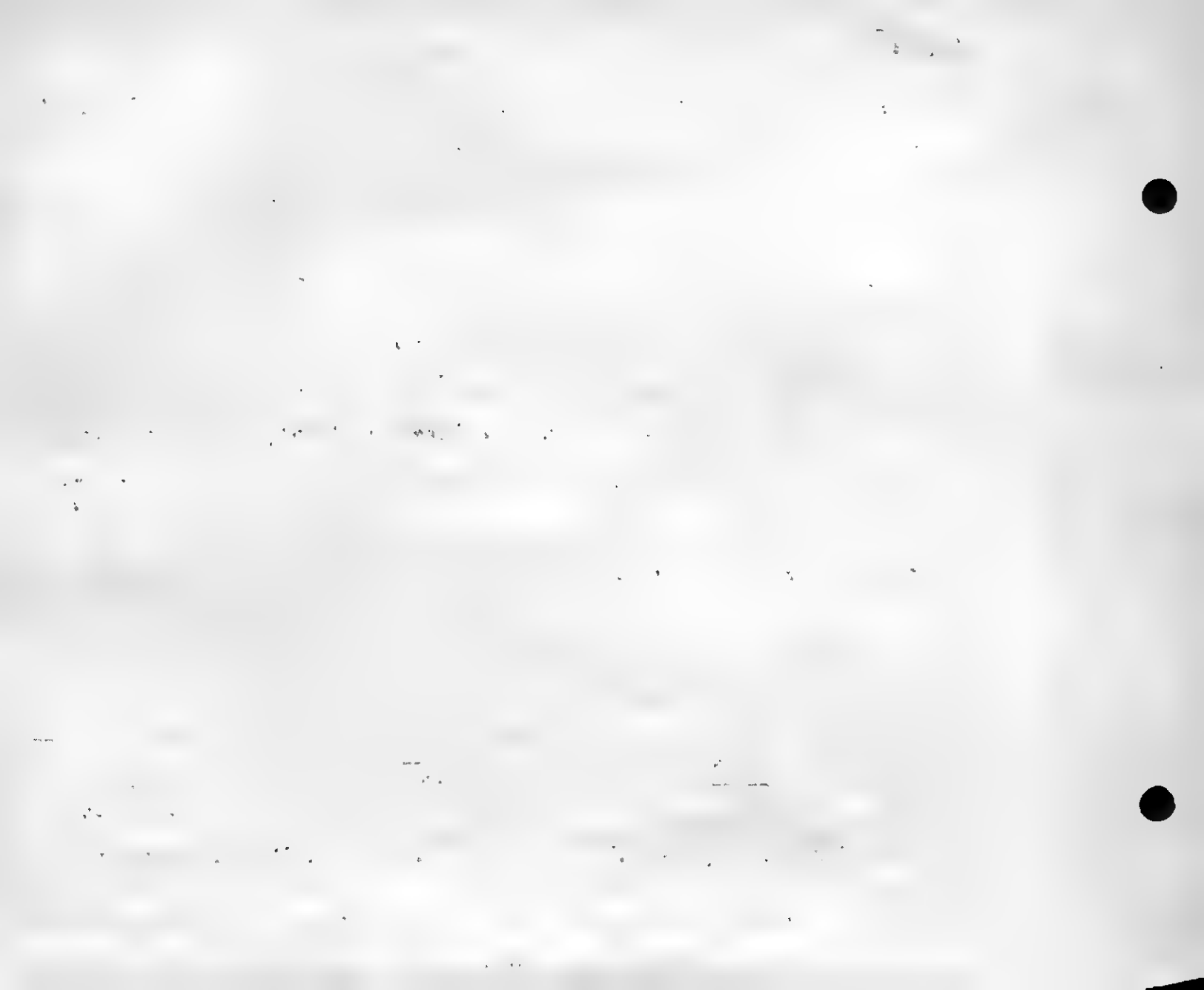
1. DECEASED-NAME (Type or print) First Middle Last <b>Etta Adams Frantz</b>			2a. DATE OF DEATH Month Day Year <b>March 5, 1969</b>		2b. HOUR <b>9:00 P M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 2, 1873</b>		6. AGE (in years last birthday) <b>95</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Washington</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fahrney- Keedy Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clearspring</b>	
13d. INSIDE CITY (44 157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last <b>Jane C. Adams</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Henriette Eddy</b>		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO. <b>220-146-9541</b>		17. INFORMANT Address <b>Mrs. R. Leon Cushwa, Clearspring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per. for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiac disease</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10, 1968</b> , to <b>March 5, 1969</b> , that (I) (we) lost the deceased alive on <b>March 5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>G. W. Levan M.D.</b>		22c. DATE SIGNED <b>March 7, 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>G. W. Levan M.D.</b>	
22e. ADDRESS <b>Boonsboro, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3- 8- 69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Clearspring Wash. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>March 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
Loma May Frye						March 23 1969		7.30 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		March 5 1908		61 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Greenwood, Va.		USA.				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown, Md.		Washington County Hosp		Domestic					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				42 Bloom Ave	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Joseph Frye						Rose Ware			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no			223-32-7835		Mrs. Rosa M. Russ 42 Bloom Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastasis to Liver &amp; Abdominal Viscera Generally</b>								8 weeks	
1574 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of the Pancreas</b>								7 months	
DUE TO, OR AS A CONSEQUENCE OF								certain	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<b>Hypertensive and Atherosclerotic Heart Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> , 19 <b>68</b> , to <b>Mar 23</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Mar 22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Pronounced dead by Dr. Graff.</b>									
22b. SIGNATURE <i>W. T. Layman</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Mar 24 1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>					22e. ADDRESS <b>301 E. Antietam Street, Hagerstown</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<b>Burial</b>		<b>3-27-1969</b>		<b>Greenwood Cemetery</b>		<b>Greenwood Rockingham Va.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>John R Watson Jr Hagerstown Md.</b>					25b. REC'D BY REGISTRAR <b>MAR 26 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Richard J. Jones</i>		

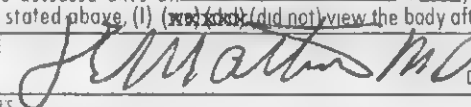
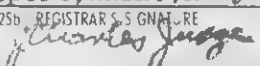


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04573

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04566  
CERTIFICATE OF DEATH

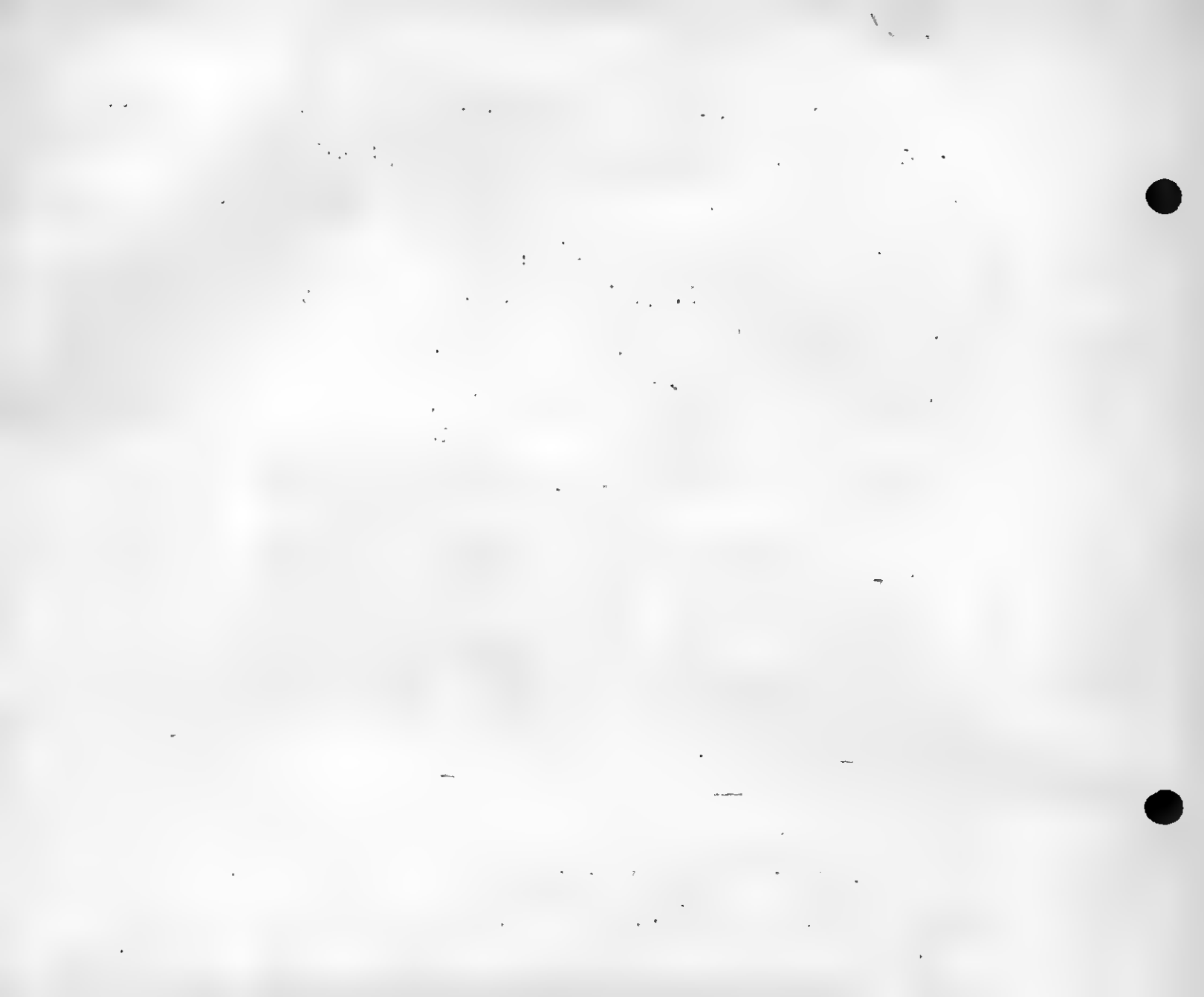
1 DECEASED NAME (Type or print) <b>William Henry Gesford</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1969</b>		2b. HOUR <b>9:42P</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 20, 1896</b>		6 AGE (In years last birthday) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Washington</b> Md		
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Building</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INS DE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>1107 Pope Ave.</b>	
14 FATHER'S NAME First Middle Last <b>William Gesford</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Catherine Davis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>World War 2</b>		16b. SOCIAL SECURITY NO. <b>220-09-9228</b>	17 INFORMANT <b>1107 Pope Ave. Hagerstown, Maryland</b> <b>Daisy Miller//</b>		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myelocytic leukemia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3/1/69</b>
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/2, 1964</b> , to <b>3/12, 1969</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>3/12, 1969</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <b>did not</b> view the body after death.					
22b. SIGNATURE 		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>3/14/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Donald E. Martin, M.D.</b>		22e. ADDRESS <b>363 S. Cleveland Ave., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 15, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Williamsport, Wash., Maryland</b>	
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport, Maryland.</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1969</b>		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04574		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04567	
Item 23 Film 410 3/11/69 kk							
1. DECEASED-NAME (Type or print) First Middle Last Carey Reid Goodloe						2a. DATE OF DEATH Month Day Year March 3, 1969	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH June 29, 1904		6. AGE (In years last birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington County, Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 130 West Bethel Street							
14. FATHER'S NAME First Middle Last Don Speed Smith Goodloe				15. MOTHER'S MAIDEN NAME First Middle Last Fannie Lee Carey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 218-24-0168		17. INFORMANT Address Dorothy B. Goodloe 130 W. Bethel St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis with thrombosis Indefinite DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral thrombosis with hemiparesis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February 3, 1969, to March 3, 1969, that (I) (we) lost the deceased alive on March 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. B. Kneisley, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/69	
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22e. ADDRESS 148 West Washington Street Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Sailand Prince George Md	
24. FUNERAL DIRECTOR John R. Watson Jr.		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04568

04575

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
CLARENCE			EDWARD		HARRAUGH	MARCH 4 69			5 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		WHITE		NOVEMBER 17, 1997		71 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
PENNSYLVANIA		U.S.A.				WASHINGTON					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work or life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		WASHINGTON COUNTY HOSP.		RET ASST GEN STORE MGR.		PE					
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON		HAGERSTOWN				935 MULLEARY A. ENUE			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
AARON			I		HARRAUGH	MILDA			C		COUSE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		934 Address		MULLEARY A. ENUE			
YES		471		474-10-4649A		MRS ANNA HARRAUGH		HAGERSTOWN, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction &amp; Peritonitis</u> 24 hrs											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Carcinomatosis</u> 1 1/2 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Bladder</u> 3 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>March 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 19 <u>69</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <u>John A. Moran M.D.</u>						22c DATE SIGNED <u>3/5/69</u>					
22d PHYSICIAN'S NAME (Type) <u>JOHN A MORAN, M. D.</u>						22e ADDRESS <u>215 W WASHINGTON ST., HAGERSTOWN, MD.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <u>3/7/69</u>			23c NAME OF CEMETERY OR CREMATORY <u>GREEN HILL CEMETERY</u>			23d LOCATION (City or Town) (County) (State) <u>MAYLESBORO, FRANKLIN, PENN.A.</u>		
24 FUNERAL DIRECTOR <u>Em Kauger</u>						25a REC'D BY REGISTRAR <u>Charles Judge</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
HAGERSTOWN, MARYLAND						DATE <u>MAR 10 1969</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1344  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04576					04563				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last <b>William Emory Harshman</b>					Month Day Year <b>March 11, 1969</b>			12:00P M	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
Male		White		March 29, 1901		67 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Beaver Creek, Md.		U. S. A.				Washington Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown			DOA Washington Co. Hospital			Truck Driver		Fuel Oil	
13a U.S. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Washington		Chewsville					
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
John Emory Harshman				Molly Eccard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
No.			220-34-2337		Mrs. Phoebe Harshman, Chewsville, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heavy familial Amyloidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1962</u> to <u>March 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Sidney Horowitz</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>3-12-69</u>			
22d PHYSICIAN'S NAME (Type) <u>SIDNEY HOROWITZ</u>				22e ADDRESS <u>FURKSTOWN MD</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3- 14- 69		Beaver Creek Cemetery		Beaver Creek, Wash. Co., Md.			
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md				MAR 17 1969		<u>William H. Under</u>			

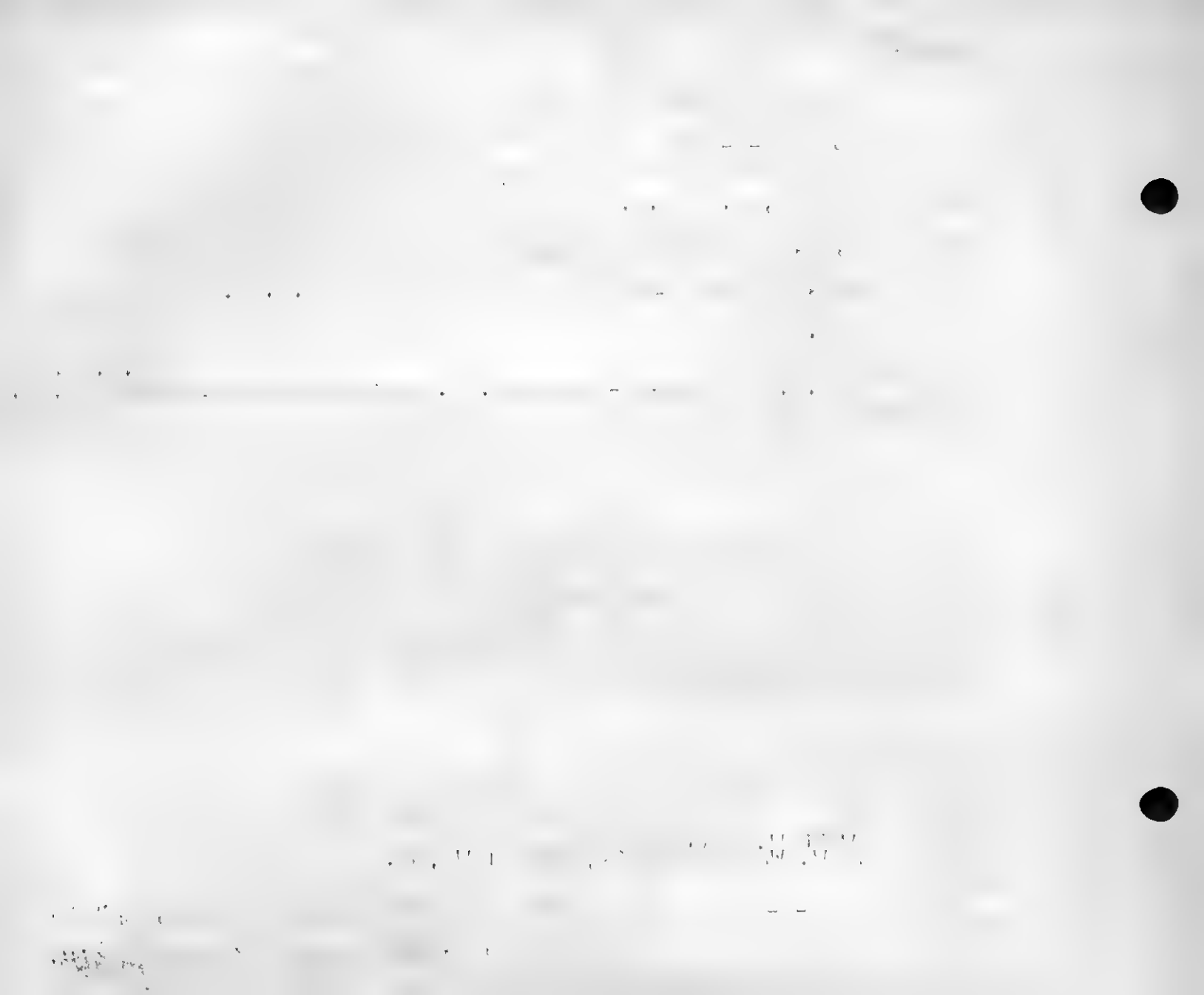


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04570							
04577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year			2b. HOUR M					
JAMES GROVER HENRY									3 29 1969			4 12 M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR M			
Male		White		3-6-1893		76 YRS						3 29 1969		4 30 M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH								
Franklin County, Pa.			U.S.						Washington					Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown, Md.			Washington County			Baker			Baking								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Penna.			Cumberland			Shippensburg			NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>			R.D. 1.					
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First		Middle		Last	
James W. Henry									Elizabeth Jones								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If not give year or date of service)			17 INFORMANT			ADDRESS								
Yes			W.W. 1			171-28-5336			Mrs. J. Grover Henry			Shippensburg, Pa.			R.D. 1.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism &amp; Bleed</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute Lobular Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cranio-Cerebral Trauma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48-72 hr</u> <u>5-10 days</u> <u>24 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
March 9, 1969			Subdural Hematoma			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR, A.M. <u>5:20 P.M.</u> <u>3-5</u> <u>1969</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State											
			Home			Rt #1 Shippensburg Franklin Penna											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			EDWARD W. DITTO III, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED								
EXAMINER'S NAME (Type)			217 W. WASHINGTON ST, HAGERSTOWN, MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			3-29-69								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			4-2-1969			Spring Hill Cemetery			Shippensburg, Pa.								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Shippensburg, Pa.			Shippensburg, Pa.			APR 3 1969			J. Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
04578		CERTIFICATE OF DEATH						04571									
1 DECEASED NAME (Type or print)			First Anna			Middle Virginia			Last Herbert			2a. DATE OF DEATH Month March Day 17 Year 89			2b. HOUR 4:05 A.M.		
3 SEX Female			4 RACE White			5 DATE OF BIRTH Feb. 13 1891			6 AGE (In years last birthday) 78 YRS			7 UNDER 1 YEAR MONTHS DAYS			8 UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md. Washington			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Washington Md								
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 43 W. Salisbury St.					
14 FATHER'S NAME First Cyrus			Middle M.			Last Davis			15 MOTHER'S MAIDEN NAME First Emma			Middle Shipley			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown No			(If yes give war or dates of service) -----			16b. SOCIAL SECURITY NO 219-34-5623			17 INFORMANT Address Mr. Benjamin Franklin Herbert Williamsport Md								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Bronchitis and Pericarditis</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1969</u> , to <u>March 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE <u>Francisco B. Rossillo</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) Francisco B. Rossillo			22e. ADDRESS Hagerstown, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 19-69			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.								
24 FUNERAL DIRECTOR Albert L. Leaf			ADDRESS Williamsport, Md.			25a. REC'D BY REGISTRAR MAR 21 1969			25b. REGISTRAR'S SIGNATURE								









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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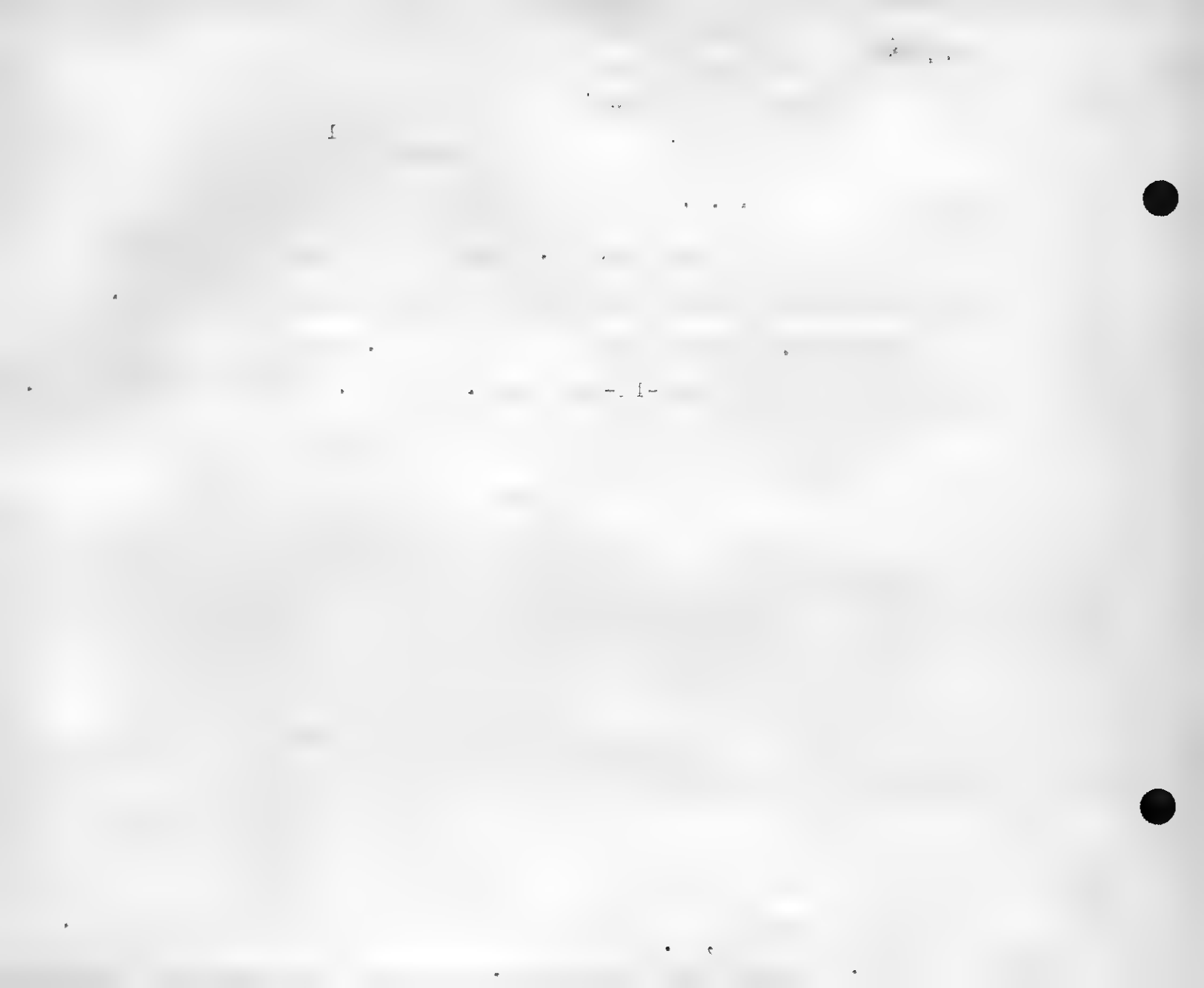
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04580

04573

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Besse		Brandt		Horn	March 15, 1969		307 AM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	White		1891 January 18,		78 YRS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Washington Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if let red)		12b KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington Co. Hospital		House Wife		Own Home			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY (UM 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		600 Preston Rd.	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Thomas A. Poffenberger					Annie B. Murrey				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOC AL SECURITY NO.		17 INFORMANT		830 The Terrace			
No		None		Mrs. Julia B. Hoopes		Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> <u>485x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Adeno-Carcinoma of the urinary tract with multiple bone metastases</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Feb. 1968		Adeno-C. of urinary tract		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes.			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING ETC)		21f LOCATION		Street or R.F.D. No.		City or Town	County State
				Feb.		1968		March 15,	1969
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1968, to March 15, 1969, that (II) (we) last saw the deceased alive on Feb. 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
B. B. Kneisley M.D.		3-17-69		B. B. KNEISLEY					
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		1969 March 18,		Rose Hill Cemetery		Hagerstown, Maryland.			
24 FUNERAL DIRECTOR		Hagerstown, Md.		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home Inc.						March 18 1969			



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1

04581

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04574

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Ruth Naomi Huffer						March 1, 1969			5:45P M		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		# UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female		White		Jan. 29, 1893			76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Chewsville, Md.		U. S. A.					Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Boonsboro			Fahrney- Keedy Mem. Home			Housewife			Own Home		
13a. U.S.A. RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. OR CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Washington			Boonsboro			314 N. Main St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Charles Baker						Fannie Shifler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			314 N. Main St.		
No.			219-54-0492			Mr. Clarence E. Huffer, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cardio vascular disease</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1968, to March 1, 1969, that (I) (we) lost saw the deceased alive on Feb. 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. W. LeDor M.D.</u>						22c. DATE SIGNED March 3, 1969					
22d. PHYSICIAN'S NAME (Type) <u>G. W. LeDor</u>						22e. ADDRESS Boonsboro.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3- 3- 69			Boonsboro Cemetery			Boonsboro Wash. Co., Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						MAR 6 1969			<u>Clarence E. Huffer</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

04582

04575

1. DECEASED NAME (Type or print) <b>Helen Marie Hussey</b>			2a. DATE OF DEATH <b>3</b> Month <b>21</b> Day <b>69</b> Year			2b. HOUR <b>9:45</b> P.M.				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>3-2-1892</b>		6. AGE (In years birth day) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) <b>Clearview Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during usual waking life, or retired.) <b>business office</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dept Store</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>203 Marbern Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Harvey Jones</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Estell French</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Warren Conner</b>			Address <b>Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disease, Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Arteriosclerosis (7 yrs)</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 1962</b> to <b>Mar 1969</b> , that (I) (we) last saw the deceased alive on <b>June 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE <b>B. B. Kneisley M.D.</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/24/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>B. B. KNEISLEY, M.D.</b>					22e. ADDRESS <b>148 W. Wash St. Hagerstown Md.</b>					
23a. BURIAL, CREMATION, or other disposition <b>burial</b>		23b. DATE <b>3-26-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Levant Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Levant, New York</b>				
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>					ADDRESS <b>Hagerstown, Md.</b>		25a. RECEIVED BY REGISTRATION <b>MAR 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





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04583

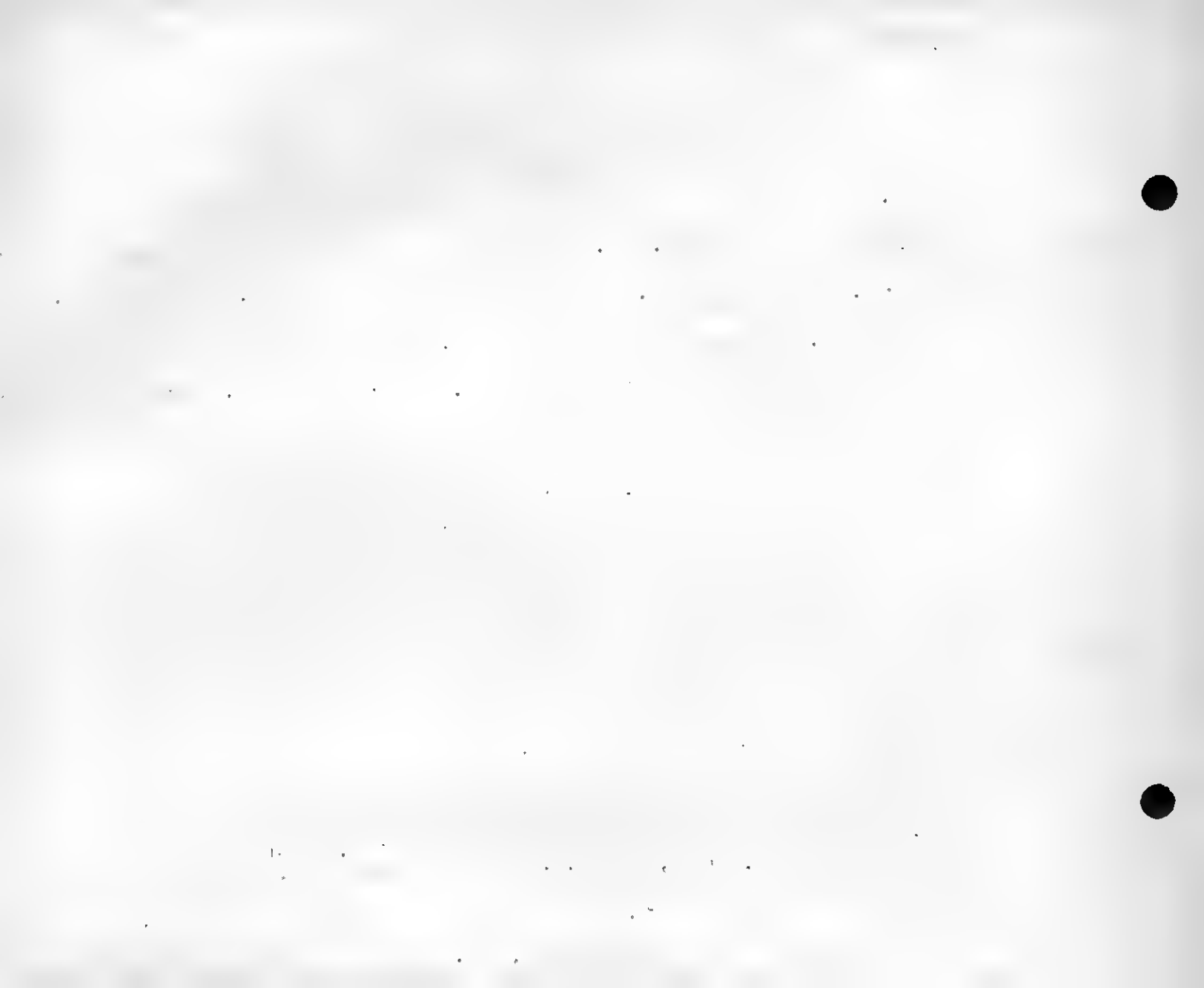
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04576

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Leister Ragon Isanogle</b>			2a DATE OF DEATH <b>3 Month 15 Day 69 Year</b>			2b HOUR <b>M</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>2-12-1905</b>		6. AGE (In years (or birthday) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.					
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>deputy</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Sheriff, Dept.</b>		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Wash.</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>155 S. Mulberry St.</b>		
14 FATHER'S NAME First Middle Last <b>John W. Isanogle</b>					15 MOTHER'S MAIDEN NAME First Middle Last <b>Eleanore Bachtell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO. <b>217-12-2411</b>		17 INFORMANT Address <b>Mrs. Joyce Isanogle, Hagerstown, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis -</b>									<b>20-30 min</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease and</b>									<b>10-15 min</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 9, 1963</b> , to <b>Mar 15, 1964</b> , that (I) (we) last saw the deceased alive on <b>Mar 5, 1964</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward W. Ditto III</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>3-17-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, III, M.D.</b>						22e. ADDRESS <b>217 W. WASHINGTON STREET HAGERSTOWN, MARYLAND</b>					
23a. BURIAL CREMATION, etc. <b>buried</b>			23b. DATE <b>3-18-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sharpsburg, Md.</b>		
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>						ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR 113  
45M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Wilbur Samuel Jennings						March 11, 1969		2:00A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Sept. 23, 1884		84 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Brownsville, Md.		U. S. A.				Washington			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Brownsville				Farmer		Farming			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Brownsville					
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Samuel Jennings						Annie Spielman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No.				220-34-0952		Mrs. S. Katherine Jennings		Brownsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> <u>517X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Cor pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary fibrosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>47 years</u> <u>7 years</u> <u>7 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> , 19 <u>64</u> , to <u>3-11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Joseph Secundari</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>3-11-69</u>			
22d. PHYSICIAN'S NAME (Type)		JOSEPH SECONDARI		22e. ADDRESS		BOONSBORO Md			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3-13-69		Brownsville Cemetery		Brownsville, Wash. Co., Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE	
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						MAR 17 1969		<u>John H. Bast, Jr.</u>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

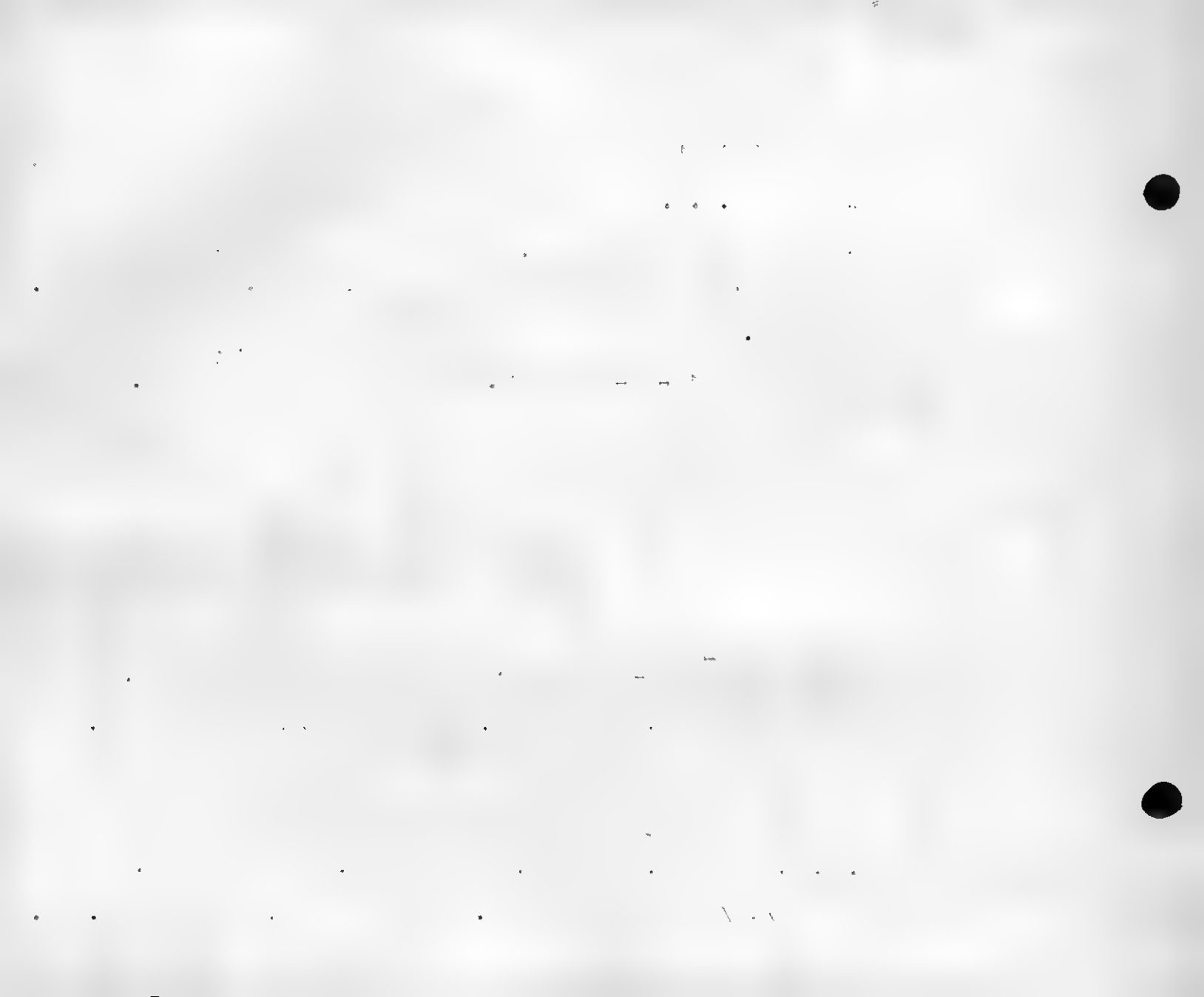
04585

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04578

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
JOHN		BALLY		KEENER				MARCH 21 1969		7:30 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
MALE	WHITE	7/19/1885	83 YRS					March 21 1969		7:30 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
MARYLAND		U.S.A.				WASHINGTON					
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		WASHINGTON CO. HOSPITAL		RETIRED FARMER		OWN FARM					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b CITY OR TOWN		13c STREET AND NUMBER		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MARYLAND		WASHINGTON		HAGERSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				38 W. LONGMEADOW RD.	
14 FATHER'S NAME		First Middle Last		15 MOTHER'S MAIDEN NAME		First Middle Last					
JOHN		S. KEENER		MARY		BALLY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		HAGERSTOWN					
NO		218-38-1462		MRS. MARK KEENER		MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Compound fracture both left &amp; right femur</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR <u>7:12 P.M.</u> 3-21- 19 69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Struck by auto while crossing road.</u>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Public Highway, Longmeadow Rd., R#6, Hagerstown, Washington, Md.</u>				21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				3-22-1969			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				3/24/69				PARADISE MEN. CHURCH			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR			
W. J. Womert, Hagerstown, Md.				25b REGISTRAR'S SIGNATURE				DATE MAR 26 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last THELMA ADELL KEESECKER					2a. DATE OF DEATH Month Day Year March 2, 1969			2b. HOUR 3:00 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 20, 1910		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Pleasantville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Hanes Road	
14. FATHER'S NAME First Middle Last Barton Hilliary Hanes				15. MOTHER'S MAIDEN NAME First Middle Last Annie Camisella Weaver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Annie Dunn Address Harpers Ferry, West Va. 25425					
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Hypertensive Cardio-Vascular Disease</i> (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial Infarction</i> (c) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-25-69</i> , 19 <i>69</i> , to <i>3-1-69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-25-69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) F. J. Landigohr		22e. ADDRESS 308 W. Preston Street		22c. DATE SIGNED 3-2-69					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/69		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Samples Manor, Maryland			
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS Harpers Ferry, W. Va.		25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
04587		CERTIFICATE OF DEATH						04580					
1 DECEASED NAME (Type or print)			First ALDA		Middle BELLE		Last KEESEY		2a. DATE OF DEATH Month Day Year March 26 1969		2b. HOUR M		
3 SEX Female			4. RACE White			5. DATE OF BIRTH Jan. 21 1898			6 AGE (in years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Pa.			7b CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Washington Md				
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 336 South Street			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland			13b COUNTY Washington			13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 336 South Street	
14 FATHER'S NAME First Middle Last Elmer Glee			15 MOTHER'S MAIDEN NAME First Middle Last Belle Seaburn			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No			16b SOCIAL SECURITY NO. None			17 INFORMANT Address Mr. Marle H. Glee EAST EARLE, PA..	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Glut arteriosclerosis + Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Disease</u> 20 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mins.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chc Dislocation of rt. femur</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 10</u> , 19 <u>65</u> , to <u>Mar 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 9</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Edward W. Ditto</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-28-69				
22d. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.						22e ADDRESS 217 W. WASHINGTON STREET HAGERSTOWN, MARYLAND							
23a BURIAL, CREMATION REMOVAL (Specify) Burial			23b DATE March 29, 1969			23c NAME OF CEMETERY OR CREMATORY Riverview Cemetery			23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Maryland				
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Md						25a RECEIVED BY REGISTRAR DATE APR 1 1969			25b REGISTRAR'S SIGNATURE <u>William Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

04588		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04581	
1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR
Simon		Welty	Kindle		March 11 1969		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER YEAR MONTHS DAYS
Male		White		December 24, 1896		72 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Frederick Co. Md.		USA				Washington Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington Co. Hospital		Tank Truck Driver		Petroleum	
13a USUAL RESIDENCE (Where deceased lived adm ssion)		13b COUNTY		13c CITY OR TOWN		3d INS. OF CITY, LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Washington		Hagerstown		3e STREET AND NUMBER	
14 FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME First Middle Lost		
William Wesley Kindle					Martha Alice Kuhn		
16a WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
No		217-10-3153A		Mrs. Rachel Kindle 321 Frederick St. Hagerstown Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4 hr							
4410							
Condit ons, if any, which gave rise to immed ate cause (a), stating the underlying cause lost.							
(b) <u>Advanced gen'l arteriosclerosis</u> 25 yr							
OE TO, OR AS A CONSEQUENCE OF							
(c) <u>Arteriosclerotic heart &amp; disease</u>							
PART 2 OTHER SIGNIFICANT CONDI TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDI TION GIVEN IN PART 1 (a) <u>Nephrosclerosis, Benign</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERAT ON WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 1969, to <u>3-11</u> , 1969, that (I) (we) last saw the deceased alive on <u>3-11</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		22c. DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS	
<u>Edward W. Ditto III, M.D.</u>		3-11-69		EDWARD W. DITTO, III, M.D.		217 W. WASHINGTON STREET HAGERSTOWN, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		3/14/69		Rest Haven Cemetery		Hagerstown-Washington-Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR DATE		25b REG STRAR'S SIGNATURE	
Wm. C. Root		Rest Haven Funeral Chapel Hagerstown, Md.		MAR 14 1969		Yellowley	

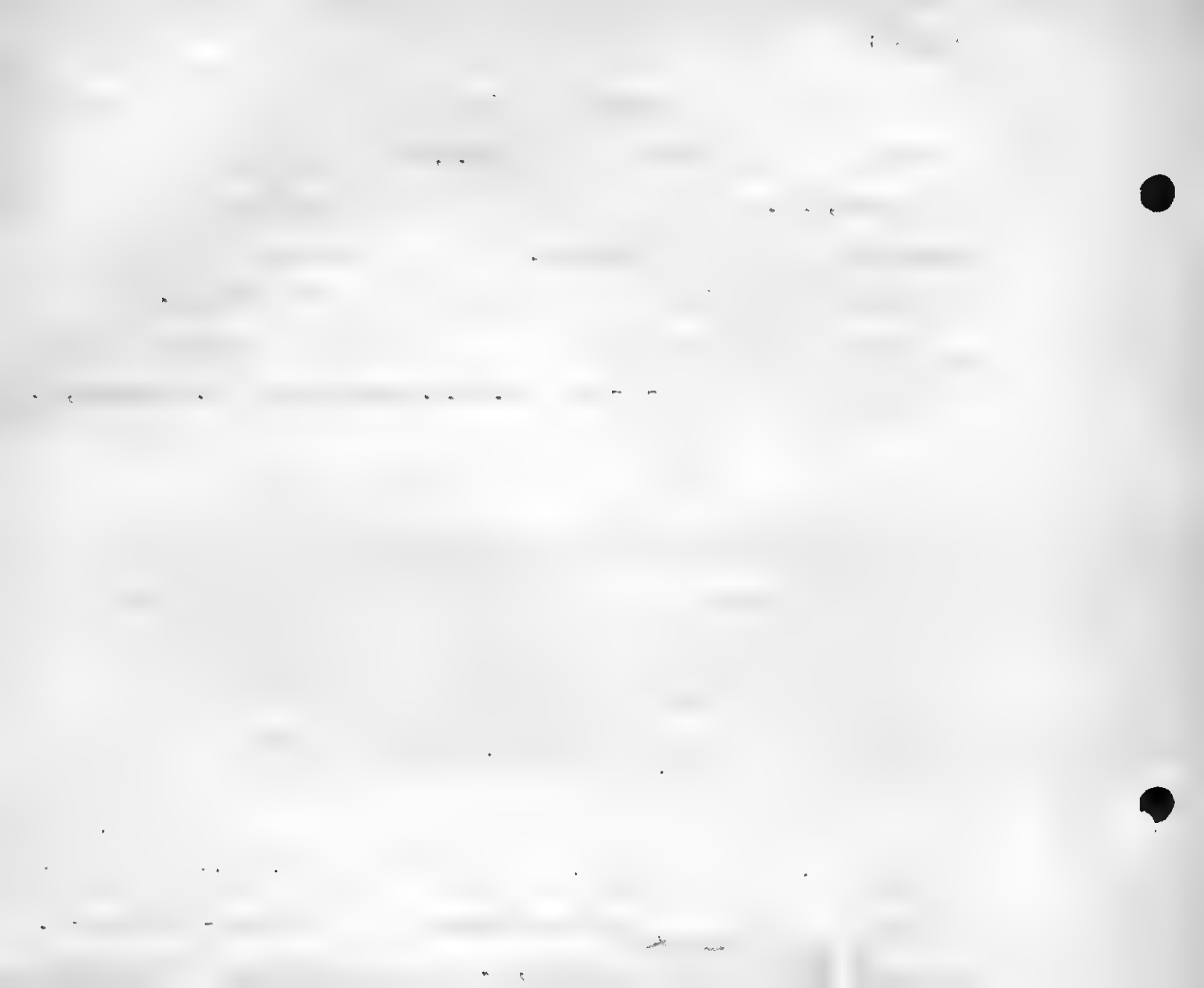


TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
45M - 1

04589		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04582	
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR
Emma Rebecca King					March 4 1969		9:50P
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Female	White		Feb. 4, 1900		69		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Great Cacapon, W. Va.		USA				Washington	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		418 Boward St.		Housewife		Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Washington		Hagerstown		418 Boward St.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
John Nelson Smith					Margaret Delena Butts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
No		217-18-7127		Mr. Geo. F. King 418 Boward St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hours Indefinite							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 24, 1963, to March 4, 1969, that (I) (we) last saw the deceased alive on Feb. 7, 1969 and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)			
B. B. Kneisley, M.D.		March 5, 1969		B. B. Kneisley, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3/8/69		Rest Haven Cemetery		Hagerstown-Washington-Md.	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE	
Wm. C. Horst		MAR 10 1969		J. Charles Judge		MAR 10 1969	
Rest Haven Funeral Chapel		Hagerstown, Md.					



04590

## CERTIFICATE OF DEATH

04583

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. fut on Residence before admission) <b>Maryland</b> <b>Washington</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e STREET ADDRESS <b>133 West Potomac St.</b>	
3 NAME OF DECEASED (Type or print) <b>Cora</b> First <b>Amelia</b> Middle <b>Kline</b> Last		4 DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>69</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 12, 1896</b> 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Hancock Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Samuel Cassidy</b>		14 MOTHER'S MAIDEN NAME <b>Narcalis Weller</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>James E. Kline</b>		Address <b>Funkstown, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>5620</b> IMMEDIATE CAUSE (a) <b>Massive hemorrhage of the gastrointestinal tract</b> DUE TO (b) <b>Perforation of the diverticulum of the duodenum and retrocecal hemorrhagic abscess</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1969</b> to <b>March 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1969</b> , and that death occurred at <b>11:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>B. B. Kneisley</i>		22b. DATE SIGNED <b>3/15/69</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 16, 69</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Hancock Wash. Md.</b>	
24. FUNERAL DIRECTOR <i>Donald E. Thompson</i>		25a. REC'D BY REGISTRAR <b>MAR 19 1969</b>	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04591		CERTIFICATE OF DEATH						04584	
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Charles Cleveland Martin						March 1, 1969			6:30 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male		White		Dec. 29, 1884		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Leitersburg, Md.		U. S. A.				Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington Co. Hospital		Farmer		Farming			
13a. USUAL RESIDENCE (Where deceased adms sion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 152 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				Rfd. 1	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
William G. Martin						Martha Hartle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		Address			
No.		220-34-0706		Mrs. Carrie L. Martin, Hagerstown Rfd. 1, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Concussive Head Trauma</u>									6 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>									6 days.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Thrombosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or RFD. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 19 <u>58</u> , to <u>3-1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles F. Hess</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-1-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Charles F. Hess, M.D.				Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-4-69		Beaver Creek Cemetery		Beaver Creek, Wash. Co., Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						MAR 6 1969		<u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04592		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04585	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or Print)		First GUY		Middle ALLEN		Last McKEE	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 12/3/1918		6 AGE (In years at birthday) 50 YRS	
				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MARCH 8 1969	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. LSLA. OCCUPATION (Kind of work done adding type of work and kind of life before (in case))		12b. KIND OF BUSINESS OR TRUCKING CO.	
13a. LSLA. RESIDENCE (Where deceased lived, if institution)		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 785 HAMILTON BLVD.		14. FATHER'S NAME First Middle Last IRA L. McKEE		15. MOTHER'S MAIDEN NAME First Middle Last PHOEBE B. BAKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war and dates of service) YES W.W.#2		16b. SOCIAL SECURITY NO 214-09-14508		17 INFORMANT MRS. CATHERINE L. McKEE		ADDRESS HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture abdominal aortic aneurysm</u> 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <u>Hypertensive Cardiac vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF 10-15 y. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-6 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Banjo nephrosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		EDWARD W. DITTO, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 3/10/69 217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN WASH. MD.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE L. J. Norment	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

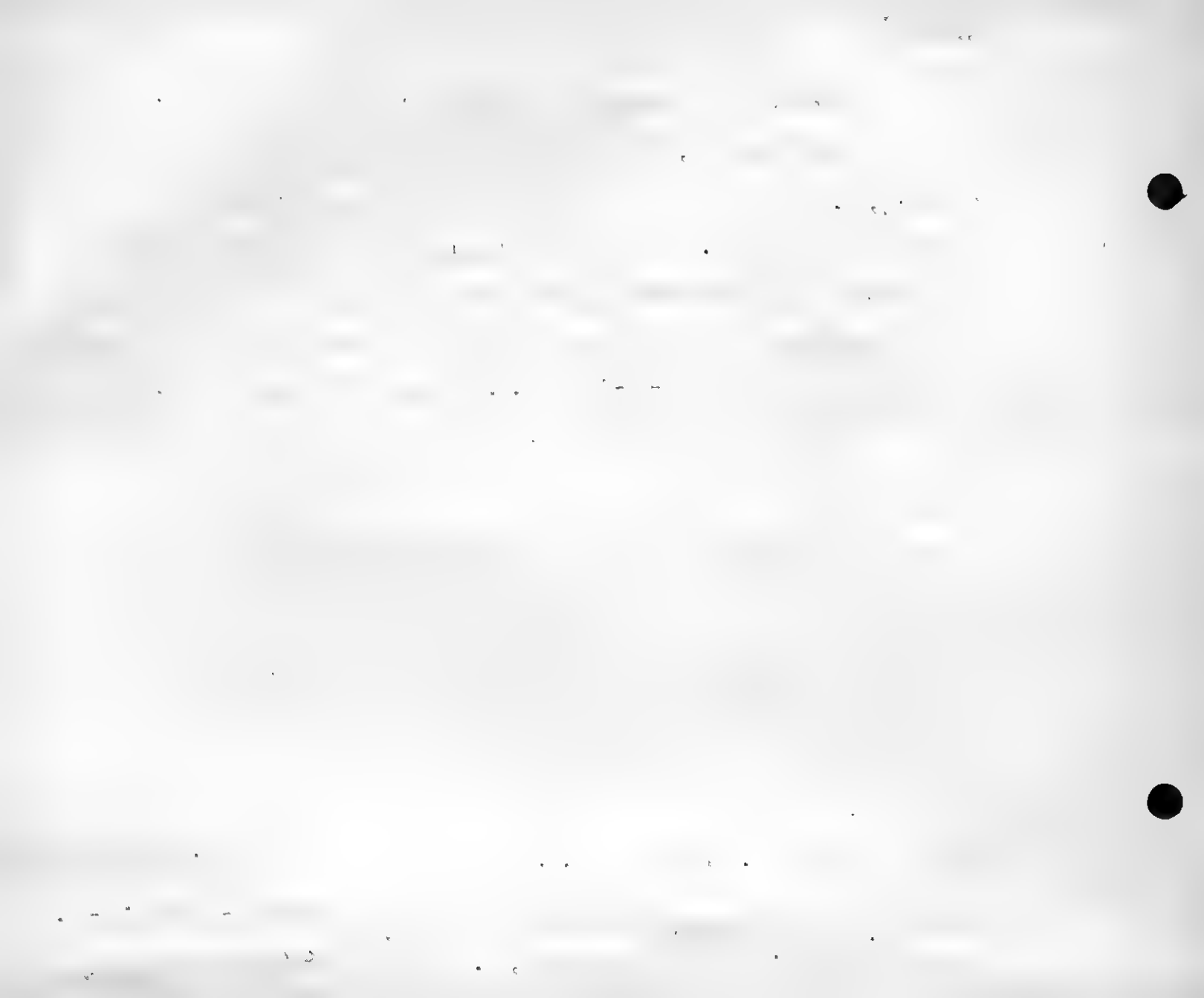
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04593

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04586

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Kathryn Mildred Mc Nairn						DATE ESTIMATED <input checked="" type="checkbox"/> 5 28 1969			7 20 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	April 22, 1902	66 YRS	MONTHS DAYS		HOURS MIN		Month 3 Day 29 Year 1969		3 25 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Clearspring, Md.		USA				Washington		Md			
10 CITY OR TOWN OF DEATH			1 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
LEITERSBURG			NR. BROOKLANE PSYCHIATRIC			Housewife			Own Home		
13a U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		465 Pangborn Blvd		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Archibald nnn Mc Nairn			Emma Highland Suffecool								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS					
N			219-20-2840			J.D. Mc Nairn 465 Pangborn Blvd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u>										I n m i d.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>1109</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
① Arteriosclerotic Heart Disease, Marked.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
2a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				2b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				7 PM 3-28-1969				Fell in stream - Wounded by Hospital			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County		State	
		Farm		Leitersburg Rural		Wash.		Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) EDWARD W. DITTO, III, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				3-31-69			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				217 W. WASHINGTON ST.			
				ADDRESS (Street, city, town, or county)				HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/1/69		Rest Haven Cemetery		Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR <u>Wm. G. Hood</u>				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Rest Haven Funeral Chapel				Hagerstown, Md.				APR 3 1969		<u>John A. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

04594

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04587

1 DECEASED-NAME (Type or print) <b>MARY MARGARET MICHAEL</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1969</b>			2b. HOUR M					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 23, 1898</b>		6 AGE (in years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>PENNA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BOOKBINDER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>W. Va.</b> COUNTY <b>MORGAN</b>			13b. CITY OR TOWN <b>BERKELEY SPRINGS</b>			13c. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>RFD # 2</b>		
14 FATHER'S NAME First <b>JOHN</b> Middle <b>MARSHALL</b> Last <b>MARSHALL</b>			15. MOTHER'S MAIDEN NAME First <b>MARTHA</b> Middle <b>WILLIAMS</b> Last <b>WILLIAMS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.	
17 INFORMANT <b>MARSHALL MICHAEL</b>			Address <b>BERKELEY SPRINGS, W. Va.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs</b> <b>10 yrs</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Pulmonary Embolism</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/69</b> , 19 <b>69</b> , to <b>5/28</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>5/27</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm. H. Hunter</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/28/69</b>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>5-31-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION</b>			23d. LOCATION (City or Town) (County) (State) <b>BERKELEY SPRINGS W. Va.</b>		
24. FUNERAL DIRECTOR <b>Wm. H. Hunter</b>						ADDRESS <b>Berkeley Springs, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## CERTIFICATE OF DEATH

04595

04588

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
Edgar		Howland	Minnich, Jr.		3 Month 24 Day 69 Year		5:20 AM		
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
male	white		9-1-1918		30 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash. Co. Hospital		welder		Metal Mfg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20 W. Baltimore St.	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
Edgar H. Minnich, Sr.					Florence J. Keefauver				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
Yes		WW 11		214-09-7481		Mrs. Sarah Jane Minnich Hag. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Coronary occlusion									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Athrosclerotic coronary artery disease Years									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 12/30, 1953, to 2/19/1969, that (I) (we) last saw the deceased alive on 2/19/1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Howard N. Weeks								3/24/69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Howard N. Weeks, M.D.			580 Northern Ave., Hagerstown						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
burial		3-27-69		Rose Hill Cemetery		Hagerstown, Md.		Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home				Hagerstown, Md.		MAR 27 1969		J. L. [Signature]	



04596

## CERTIFICATE OF DEATH

04589

1 DECEASED NAME (Type or print) Alan Lee Monninger		2a DATE OF DEATH Month Day Year March 5 1969		2b HOUR 10 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH March 4, 1969		6 AGE (In years last birthday) YRS MONTHS DAYS 10 30
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.	
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <del>Md.</del>	13b COUNTY Washington	13c CITY OR TOWN Clear Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Box 181
14 FATHER'S NAME First Middle Last Ronald Lee Monninger	15 MOTHER'S M.A.DEN NAME First Middle Last Bonita Bernice Eichelberger			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b SOCIAL SECURITY NO -----	17 INFORMANT Father Address Box 181 Clear Spring, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ATELECTASIS</u> 7764 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>PREMATURITY-</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>NONE</u>				
19a DATE OF OPERATION <u>NONE</u>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 4, 1969</u> to <u>MARCH 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>MARCH 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.				
22b. SIGNATURE <u>Archie Robert Cohen</u>	DEGREE ATTENDING PHYS.	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED 03-05-69	
22d. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN	22e ADDRESS CLEAR SPRING-MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 3/6/69	23c NAME OF CEMETERY OR CREMATORY Blairs Valley Cem.	23d LOCATION (City or Town) (County) (State) Blairs Valley, Wash. Md.	
24. FUNERAL DIRECTOR <u>Margaret Rowland</u>	ADDRESS Clear Spring, Md.	25a REC'D BY REGISTRAR DATE MAR 10 1969	25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

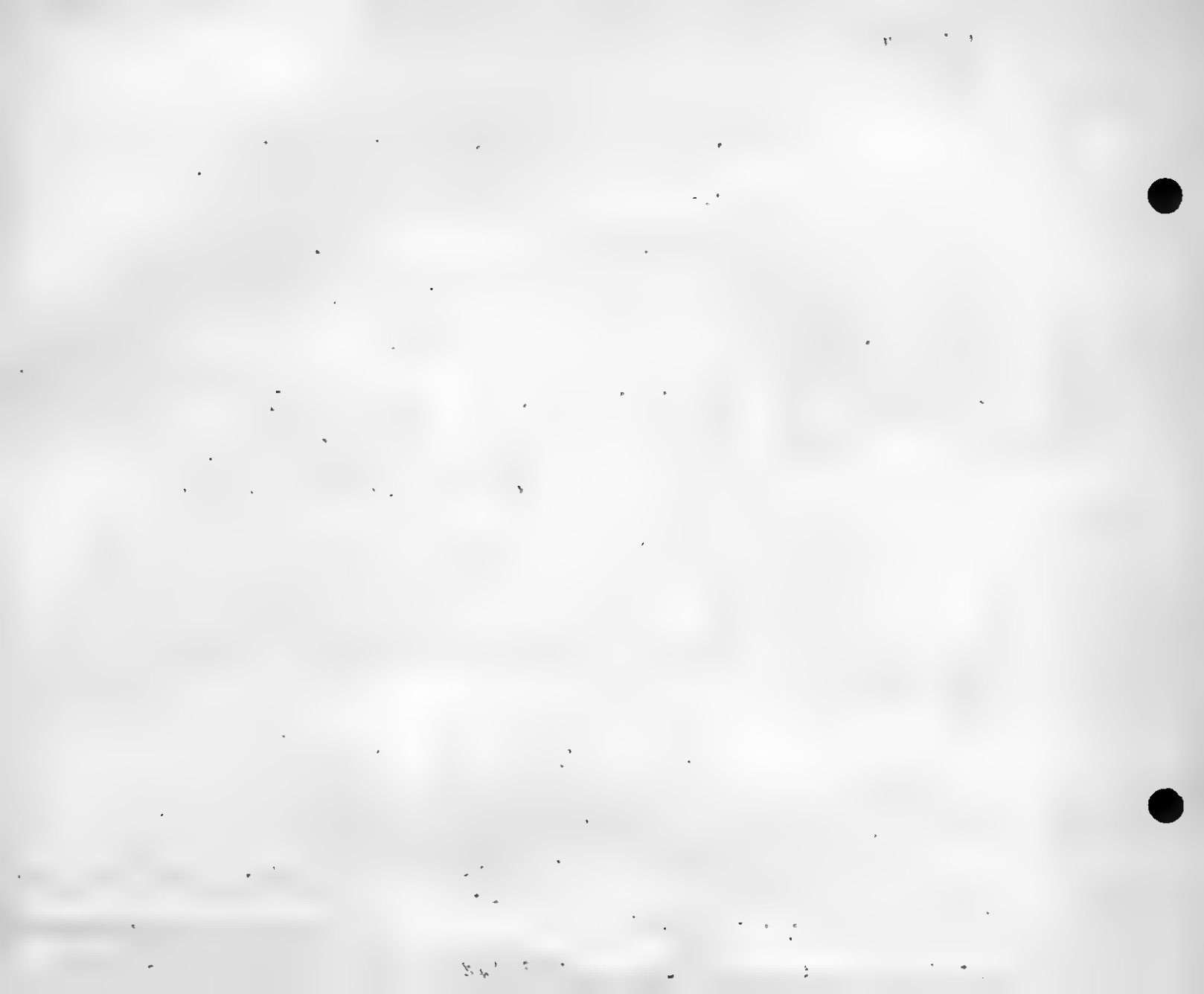
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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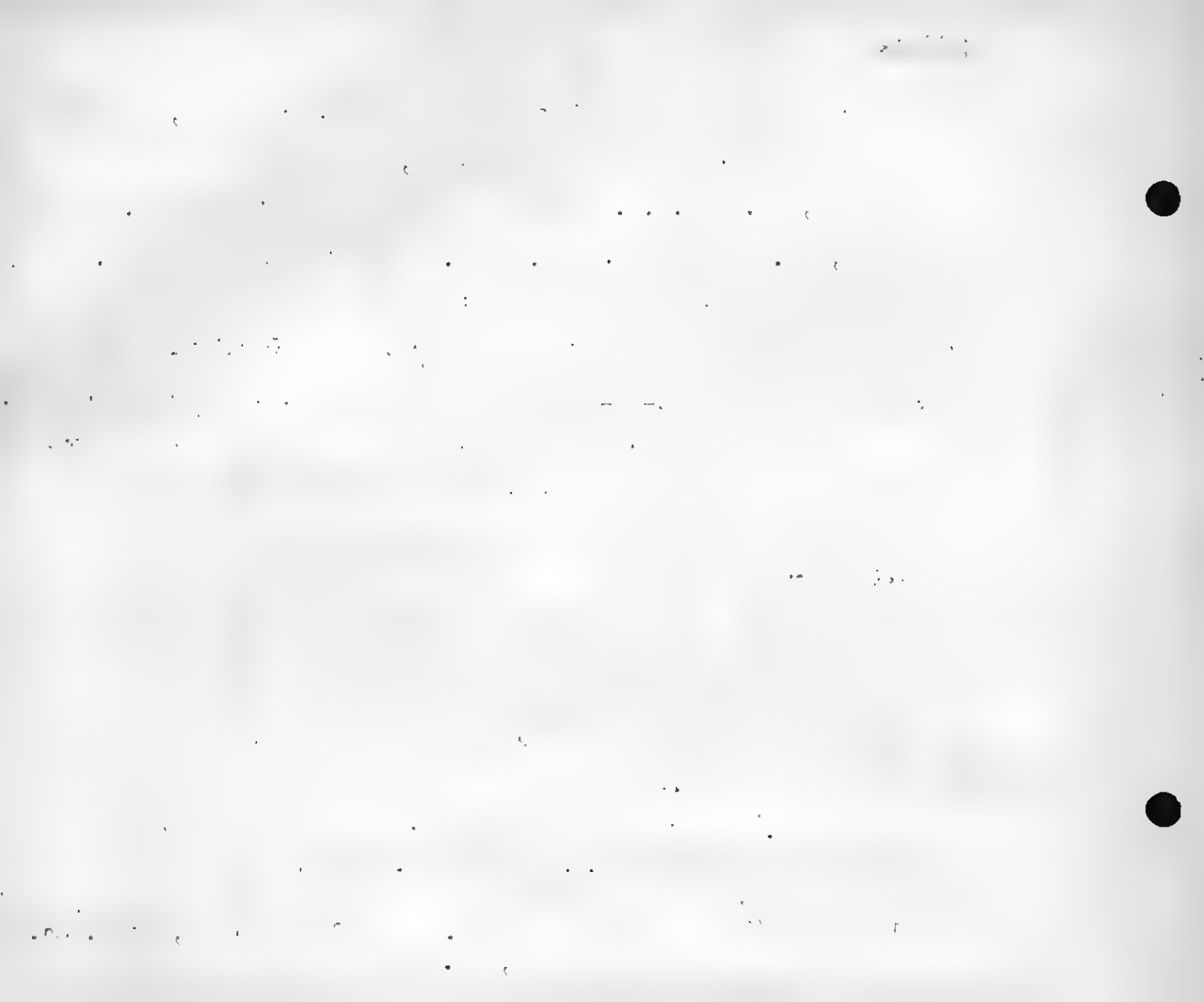
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04597 CERTIFICATE OF DEATH 04590											
1 DECEASED NAME (Type or print)			First ESTELLA		Middle MOUDY		Last MOUDY		2a DATE OF DEATH 3 Month 4 Day 69 Year		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 4.15.1883			6 AGE (In years date birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON Md					
10. CITY OR TOWN OF DEATH HAGERSTOWN			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY			12a USUA. OCCUPATION (Kind of work done during most of working life, or if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b COUNTY WASHINGTON		13c CITY OR TOWN WILLIAMSPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RURAL 2		
14 FATHER'S NAME First Middle Last CALEB FORSYTH			15. MOTHER'S MAIDEN NAME First Middle Last LOUISA SHIVES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 216.46.0058		17 INFORMANT Address AGNES L MOUDY RURAL 2 WILLIAMSPORT MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute edema of the lung</i>										5 H	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Essential Hypertension</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11.12.1968, to 3/4.1969, that (I) (we) last saw the deceased alive on 3/4.1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>FRANK ROSSILLO</i>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 3-5-69					
22d. PHYSICIAN'S NAME (Type) FRANK ROSSILLO			22e. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3.7.69		23c. NAME OF CEMETERY OR CREMATORY RIVER VIEW		23d. LOCATION (City or Town) (County) (State) WILLIAMSPORT WASHINGTON MD				
24. FUNERAL DIRECTOR Houder & Moore			ADDRESS WILLIAMSPORT MD			25a. RECD BY REGISTRAR MAR 14 1969			25b. REGISTRAR SIGNATURE <i>J. L. Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
04598		04591									
1. DECEASED-NAME (Type or print) <b>Nora Elizebeth Newkirk</b>						2a. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1969</b>			2b. HOUR <b>12:10 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 1, 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Big Spring, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington Co., Md.</b>					
10. CITY OR TOWN OF DEATH <b>Hagerstown, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Home duties</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clear Spring</b>		13d. INSURE CITY LHM 157 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>None</b>			
14. FATHER'S NAME First <b>Tunis</b> Middle <b>Ellis</b> Last <b>Newkirk</b>		15. MOTHER'S MAIDEN NAME First <b>Preston</b> Middle <b>Virginia</b> Last <b>Tice</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>220-18-3393</b>		17. INFORMANT Address <b>Miss Nellie Newkirk Clear Spring, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Annular Carcinoma of the sigmoid colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Carcinoma of the left breast</b>											
19a. DATE OF OPERATION <b>01/28/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of the Colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13/68</b> 19____, to <b>03/09/69</b> 19____, that (I) (we) saw the deceased alive on <b>03/09/69</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Archie Robert Cohen</i>		DEGREE <b>ARCHIE ROBERT COHEN</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>03/10/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22e. ADDRESS <b>Clear Spring, Maryland 21722</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/12/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Clear Spring, Wash. Md.</b>					
24. FUNERAL DIRECTOR <i>Margaret Rowland</i>		ADDRESS <b>Clear Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. Judge</i>					

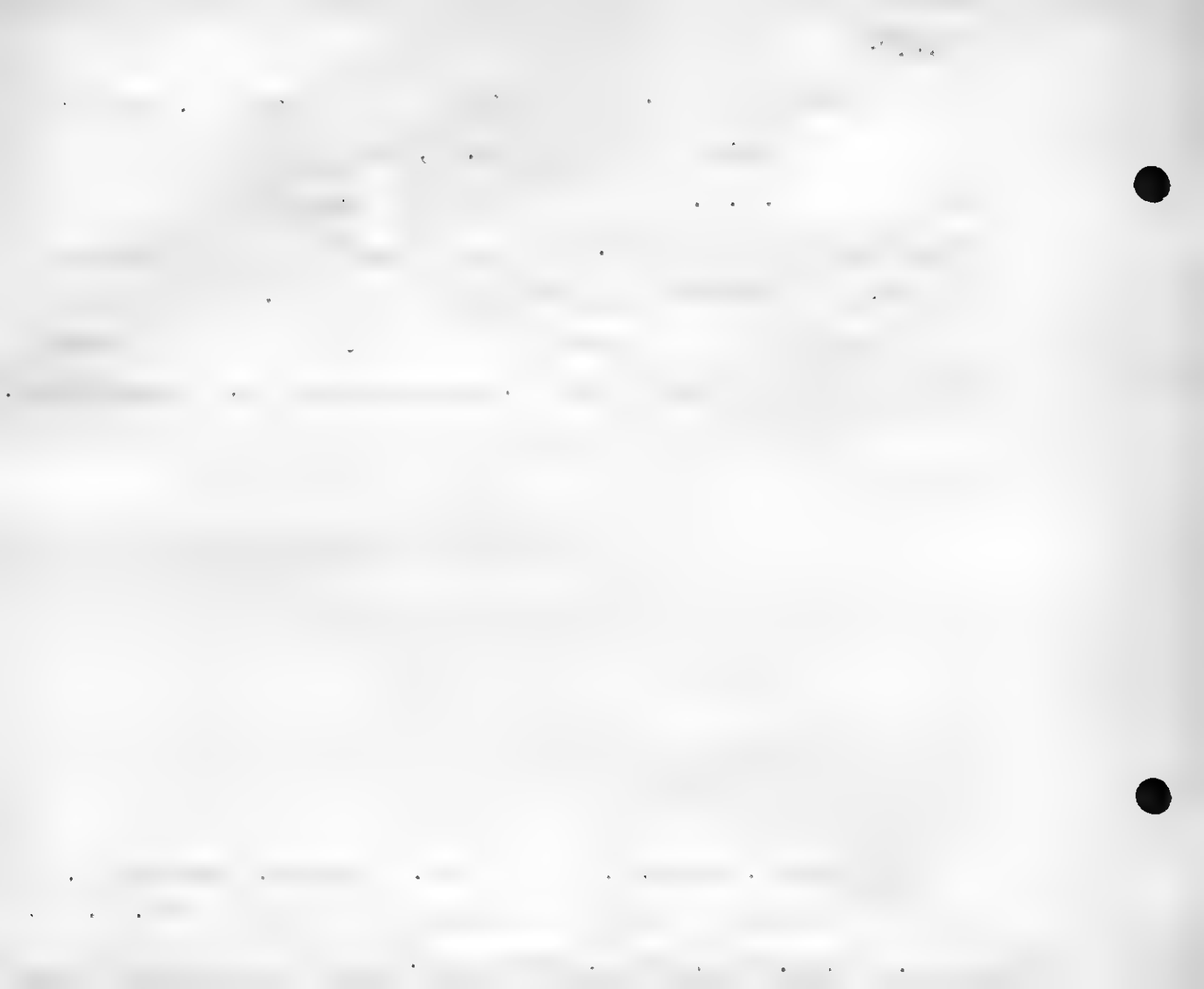




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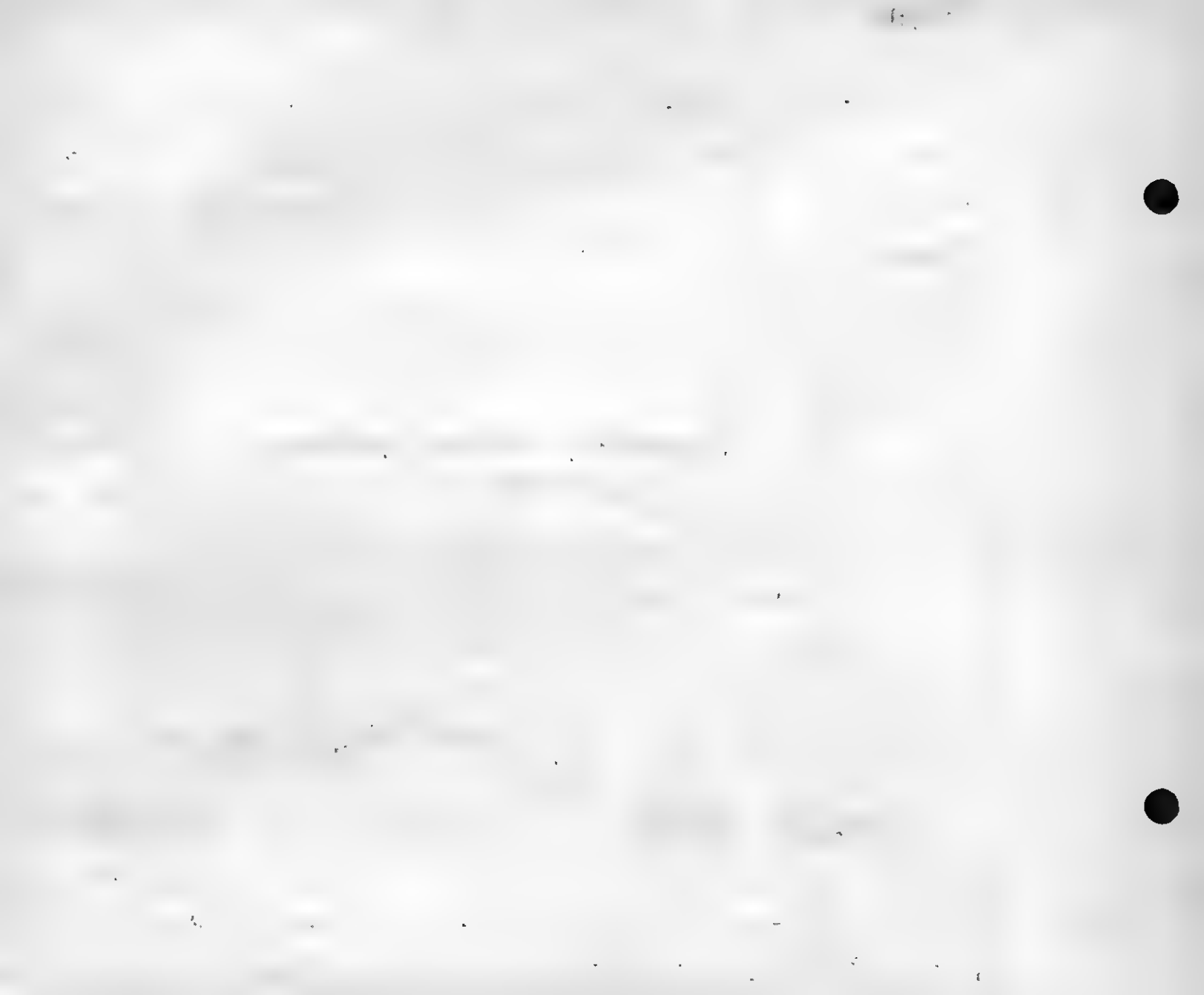
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First <b>Sam</b>	Middle <b>M.</b>	Last <b>Pashen</b>	2a. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1969</b>			2b. HOUR <b>8:30P M</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 24, 1906</b>		6. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS <b>MIN.</b>
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rfd. 3</b>		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Dealer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Livestock</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rfd. 3</b>	
14. FATHER'S NAME First <b>Morris</b>			Middle <b>Pashen</b>	15. MOTHER'S MAIDEN NAME First <b>Helen</b>			Middle <b>Unknown</b>		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Mrs. Betty Jane Pashen, Rfd. 3, Hagerstown, Md.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>67</b> , to <b>Jan</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>William O. Rexrode</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>3/5/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>William O. Rexrode, M. D.</b>		22e. ADDRESS <b>145 S. Prospect St. Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3- 5- 69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Information taken from birth certificate									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Baby			Boy			March 21 1969			12:55 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		3-21-69		YRS. MONTHS DAYS		7 38	
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Washington County Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Washington County						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		633 S. Potomac Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Hubert Lee Hall			Joan Darlene Pease						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) 77-2-2									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5:25 AM 21 Mar</u> 19 <u>69</u> to <u>21 Mar</u> 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>21 Mar</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Harold H. Hest</u>								<u>22 March 1969</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		3-26-69		WASHINGTON COUNTY HOSPITAL		HAGERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>John A. Schaffer, adm.</u>		<u>Wash. Co. Hosp.</u>		<u>DA APR 1 1969</u>		<u>Charles Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04601

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR a		
LOUIS				JOHANNES	PEDEPSEN	MARCH 1 69			4:15 a		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		APRIL 26, 1884			84 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
DENMARK		U.S.A. 1909					WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRIAL CRAFT		
HAGERSTOWN			36 S LOCUST STREET			SETTLER ASSEMBLYMAN			MANUFACTURE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			WASHINGTON		HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		36 S LOCUST STREET		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
			UNKNOWN						UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			220-01-1511A			JOHN BEAIR, SR.			564 SALEM AVE. HAGERSTOWN, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>										1 Day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										10 yrs.	
(b) <u>General Athero-Sclerosis</u>											
(c) <u>Cerebro-Vascular Insufficiency</u>										6 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Chronic Uremia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None		None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 30 to Feb 19 1969</u> , to <u>March 1 1969</u> , that (I) (we) last saw the deceased alive on <u>March 1 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. H. Peachley, M.D.</u>						22c. DATE SIGNED <u>March 4/69</u>					
22d. PHYSICIAN'S NAME (Type) J. H. PEACHLEY, M.D.						22e. ADDRESS 221 W WASHINGTON ST., HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		3/4/69		ROSE HILL CEMETERY		HAGERSTOWN, WASHINGTON, MD.					
24. FUNERAL DIRECTOR <u>Em Kauger</u>						ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE <u>MAR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Wilbur Milton Phillips						3 Month 6 Day 69 Year			5P M
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
male		white		7-24-1931		37 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. Co. Hospital			Supervisor		Truck Mfg.	
13a USUAL RESIDENCE (Where deceased lived if not at an institution before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		836 Kenly Ave.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Wilbur M. Phillips						Della A. Reed			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17. INFORMANT Address				
yes			Korean		217-18-1550 Jean Phillips Hagerstown, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									9 hr
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/6/69</u> , 19 <u>69</u> , to <u>3/6/69</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>3/6/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Robert V. Campbell</u>					DEGREE		22c DATE SIGNED		
							3/7/69		
22d PHYSICIAN'S NAME (Type) <u>ROBERT CAMPBELL</u>					22e ADDRESS <u>HAGERSTOWN MD</u>				
23a B. RIAL, CREMAT. ON, <u>BURIAL</u>		23b DATE <u>3-9-69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Minnich Funeral Home Hagerstown, Md.					DATE <u>MAR 10 1969</u>		<u>Charles Judge</u>		

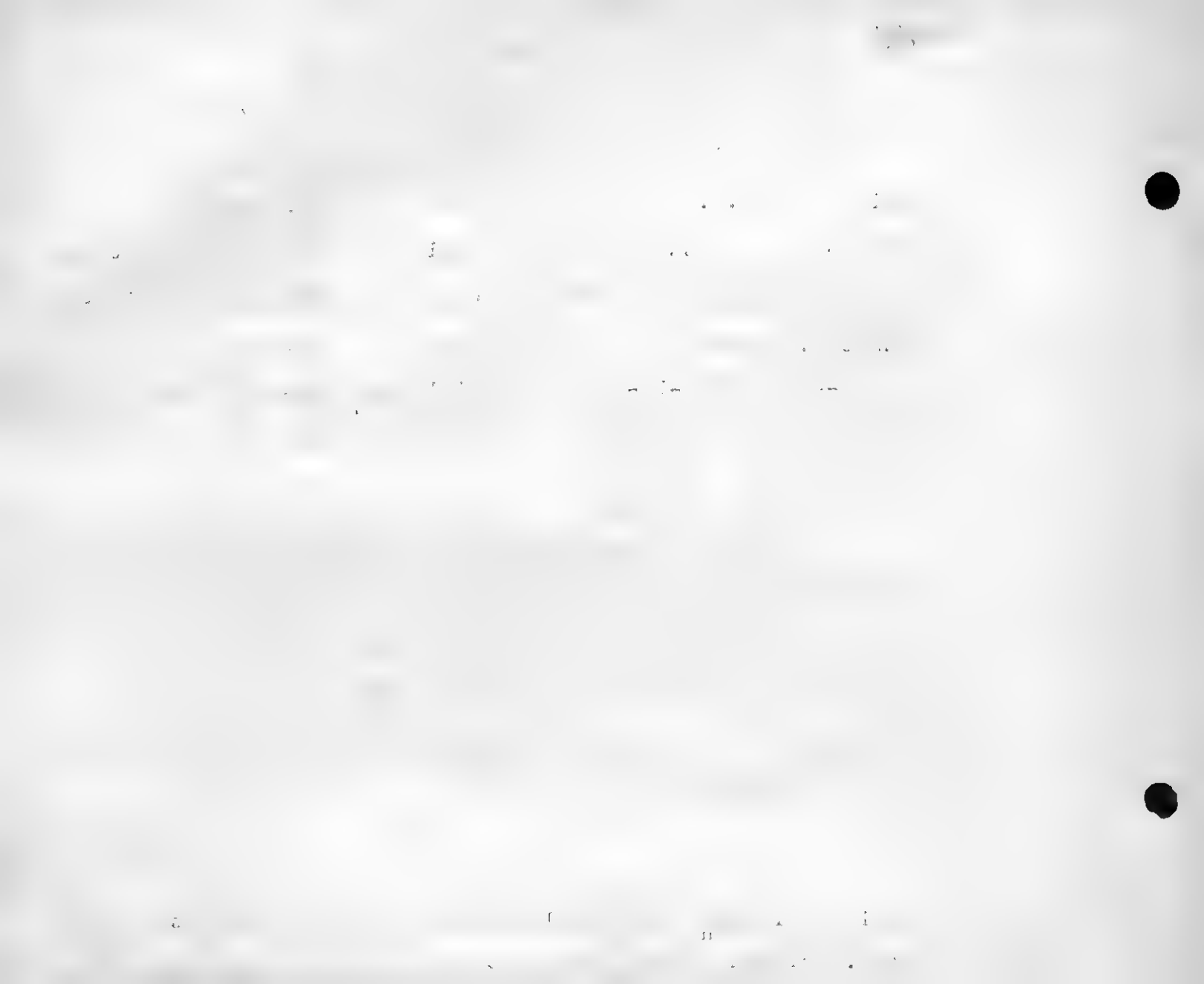




TO HOSPITAL L. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

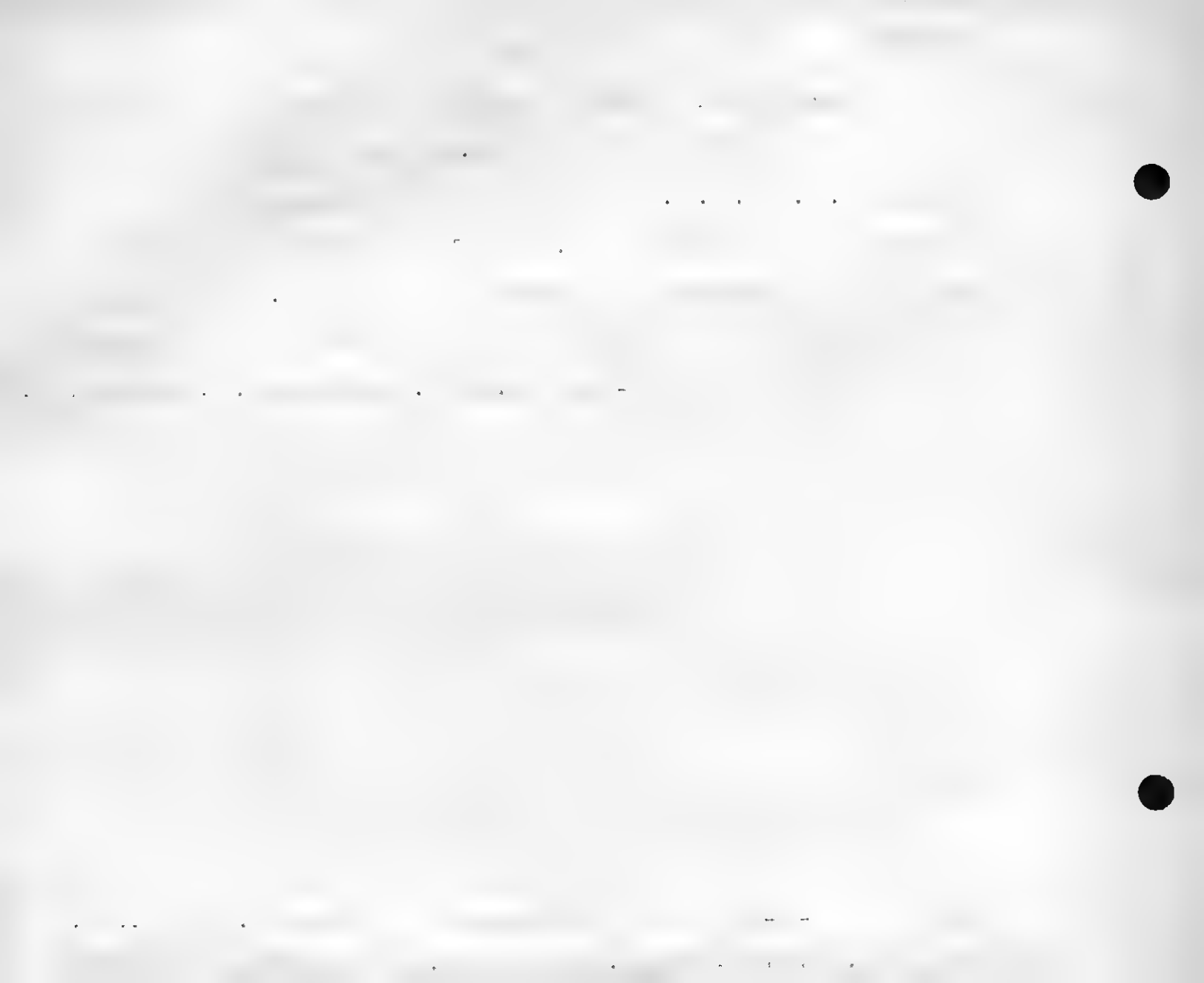
04603		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04596	
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR
ALLAN WERTER RAMSAY					March 7 1969		2 A M
3. SEX	4 RACE	5. DATE OF BIRTH			6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Male	White	March 22 1902			66 YRS.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Virginia	U.S.A.				Washington Md.		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown	Washington County Hospital		Navy Yard		Retired		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Maryland	Washington	Hagerstown		1078 So Potomac St			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Dennis M. Ramsay					Lillie N. Orrison		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
No		577-10-2928		Mrs Violet K. Ramsay		1028 So Potomac St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic gangrene right leg</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks 3 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral thrombosis due to arteriosclerosis</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1969, to March 7, 1969, that (I) <del>was</del> last saw the deceased alive on March 7, 1969, and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) view the body after death.							
22b SIGNATURE John A. Moran MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 3/7/69	
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS 215 W. Washington St. Hagerstown Md			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		3/10/69		Rose Hill Cemetery		Hagerstown Wash Co Md	
24 FUNERAL DIRECTOR Hagerstown Md				ADDRESS Andrew K. Coffman Funeral Home Inc		25a REG BY REGISTRAR MAR 13 1969	
						25b REGISTRAR'S SIGNATURE J. J. J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04604					04597				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last <b>Jack Earl Hazel Randolph</b>					Month Day Year <b>March 3, 1969</b>				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
<b>Male</b>		<b>White</b>		<b>Nov. 15, 1900</b>		<b>68</b> YRS.		<b>8:50A</b> M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
<b>Albermarle, N. C.</b>		<b>U. S. A.</b>				<b>Washington</b> Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
<b>Hagerstown</b>		<b>Washington Co. Hospital</b>		<b>Salesman</b>		<b>Auto</b>			
13a. USAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
<b>Maryland</b>		<b>Washington</b>		<b>Boonsboro</b>				<b>Rfd. 2</b>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
<b>John Randolph</b>			<b>Alice</b>			<b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
<b>No.</b>		<b>578-03-1564</b>		<b>Mrs. Ruth A. Randolph, Rfd. 2, Boonsboro, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Congenital heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Ischemic heart disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15 -</u> , 19 <u>67</u> , to <u>3-3-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-3-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Joseph H. Secordari</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3-3-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOSEPH H. SECORDARI</u>					22e. ADDRESS <u>BOONSBORO MD 21713</u>				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<b>Burial</b>		<b>3-6-69</b>		<b>Bevenola Cemetery</b>		<b>Bevenola, Wash Co., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</b>					<b>MAR 10 1969</b>		<u>Charles Judge</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04605		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						04598	
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
MARGARET KOCHENDERFER READY						3 1 1969			8:30 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS M.N.		2c. DATE PRONOUNCED DEAD	2d. HOUR
FEMALE	WHITE	DECEMBER 29, 06	62 YRS					Month 3 Day 1 Year 1969	11:42 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
W. VIRGINIA		U.S.A.				WASHINGTON			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HAERSTOWN			117 N COLONIAL DR.			RETIRED TEACHER			EDUCATION
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
MARYLAND			WASHINGTON			HAERSTOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER			
JAMES N KOCHENDERFER			MARY CRAIG			117 N COLONIAL DR.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
NO			219-36-3701			MARTHA KOCHENDERFER, CHA. LESTOWN, W. VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									<u>Fixed</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Arteriosclerotic Heart</u>									<u>15-20 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Carcinoma Pancreas</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
			P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) E. W. DITTO, III			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3/3/69			
215 W WASHINGTON ST., HAERSTOWN, MD.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			3/4/69			ROSE HILL CEMETERY			HAERSTOWN, WASHINGTON, MD.
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u>			HAERSTOWN, MARYLAND			DATE MAR 10 1969			<u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A157  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04606					04599				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last Emma (none) Reed					March Month 18 Day 1969 Year 1:49 P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR	
Female		White		7/16/88		80 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				WASHINGTON Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WESTERN MD. STATE HOSPITAL		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		140 N. Potomac St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William C. Craig			Emma Kyner Etter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no			214-09-0562		D.C. Reed 140 N. Potomac St. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia lower lobe, bilateral</u>									48 hrs
1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma of the Lung</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Rectum</u>									7 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov. 26, 1968</u> , to <u>March 18, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Fe U. Porciuncula M.D.		3/19/69		Fe U. Porciuncula, M.D.					
				22e. ADDRESS Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/20/69		Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Rest Haven Funeral Chapel Hagerstown, Md.		DATE MAR 20 1969		[Signature]					

2012



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal), and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04607					04600						
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First EDITH		Middle MAE		Last RHODES		2a DATE OF DEATH March 20 Day 1969		7b HOUR 8:30 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 9/21/1894		6 AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAY'S		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON		Md			
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give mailing address) WASHINGTON CO. HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) COOK		12b KIND OF BUSINESS OR INDUSTRY RESTAURANT			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY, LAKE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 107 EAST AVE.			
14 FATHER'S NAME First GEORGE		Middle BANZHOFF		Last ANNIE		15 MOTHER'S MAIDEN NAME First ANNIE		Middle POOLE		Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) NO		16b. SOC. SEC. SECURITY NO (If give war or dates of service) 216-05-6294		17 INFORMANT MRS. HAZEL ANDERSON		HAGERSTOWN MD?					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4121 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and Atherosclerotic Heart Disease</u> Unknown (c) <u>Unknown</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u> <u>Umbilical Hernia; Recent Partial Intestinal Obstruction; Pneumonitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 5</u> , 19 <u>69</u> , to <u>Mar 20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>W. T. Layman, M.D.</i>		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/21/69					
22d PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22e ADDRESS 301 E. Antietam St.									
23a BURIAL, CREMATION REMOVAL BURIAL		23b DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24 FUNERAL DIRECTOR <i>W. T. Layman, M.D.</i>		ADDRESS Hagerstown, Md		25a REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>					



# FOR STATE HEALTH DEPT.

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Items 18-22a Film 410 Maryland State Department of Health  
3-13-69ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04608

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04601

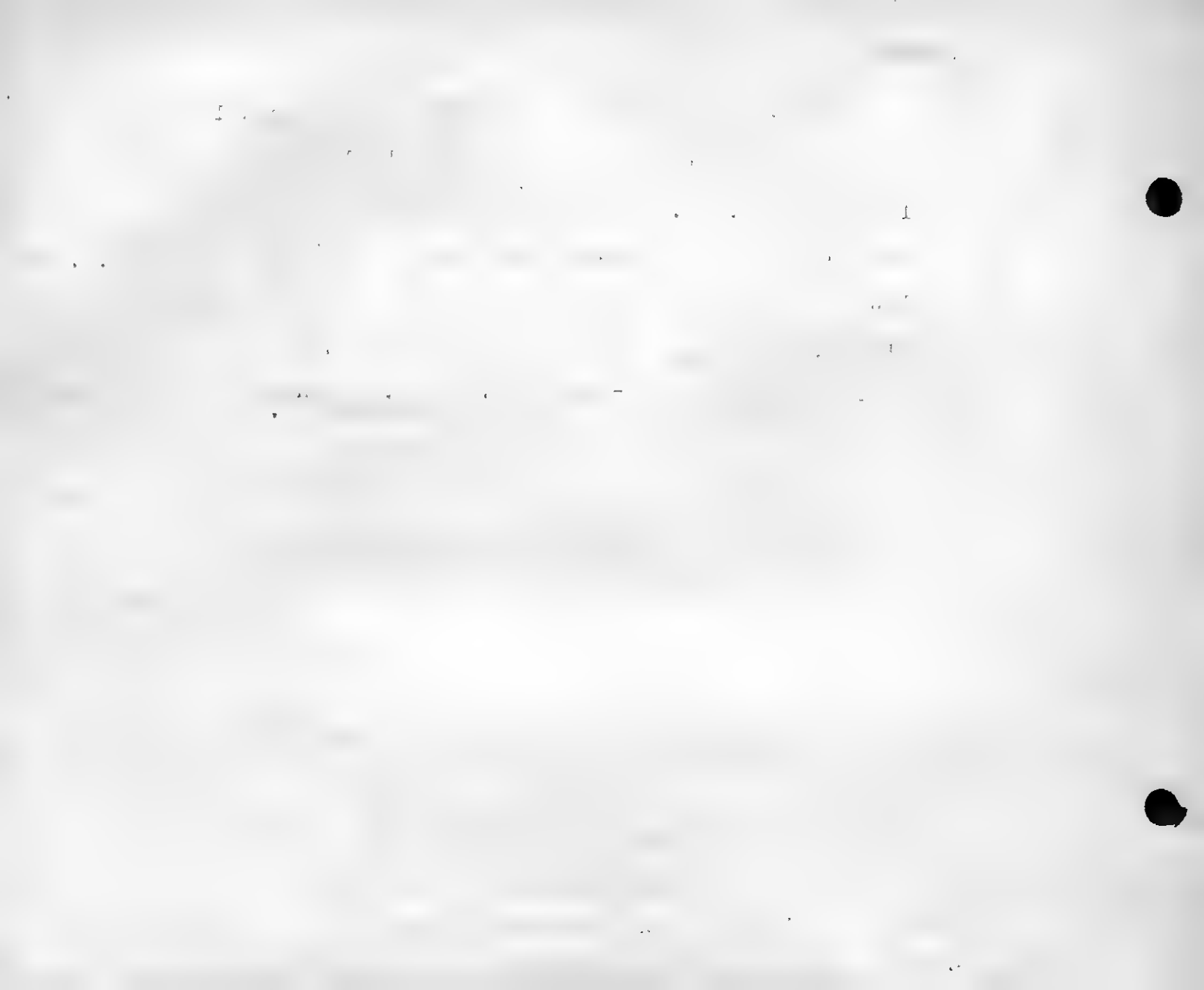
1 DECEASED NAME (Type or Print) <b>Howard Elmer Rice Sr.</b>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> March 4 1969			2b HOUR <b>7:48 PM</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>March 28 1912</b>	6 AGE (in years last birthday) <b>56</b> YRS	7 UNDER YEAR MONTHS <b>3</b>	8 UNDER 24 HRS DAYS <b>4</b>	9 COUNTY OF DEATH <b>Washington County</b>	2c DATE PRONOUNCED DEAD Month <b>3</b> Day <b>4</b> Year <b>1969</b>	
7a BIRTHPLACE (State or foreign country) <b>Jefferson Co.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Washington County</b>		
10 CITY OR TOWN OF DEATH <b>Williamsport</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Labor</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Washington</b>			13c CITY OR TOWN <b>Hagerstown</b>		
14 FATHER'S NAME <b>Harry L Rice</b>			15 MOTHER'S MAIDEN NAME <b>Ida M. Barrett</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16b SOCIAL SECURITY NO <b>220-03-2819</b>			17 INFORMANT <b>Mrs. Mary Rice</b>			18 ADDRESS <b>408 N. Prospect St. Hagerstown, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>2° burns of trunk &amp; left arm</b> DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE ALCOHOLIC INTOXICATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Acute alcoholic intoxication</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute alcoholic intoxication</b> (c) <b>Acute alcoholic intoxication</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month Day Year <b>6:30 P.M. Approx.</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>Scalded by boiling water</b>		
22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Red Men's Hall</b>			22c LOCATION Street or R.F.D. No. City or Town County State <b>Williamsport Wash. Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE <b>Edward W. Ditto, III, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>3-6-69</b>		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22c ADDRESS (Street, city, town, or county) <b>217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND</b>		
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>March 7-69</b>			23c NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		
24 FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>			25a REC'D BY REGISTRAR <b>Charles Judge</b>			25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

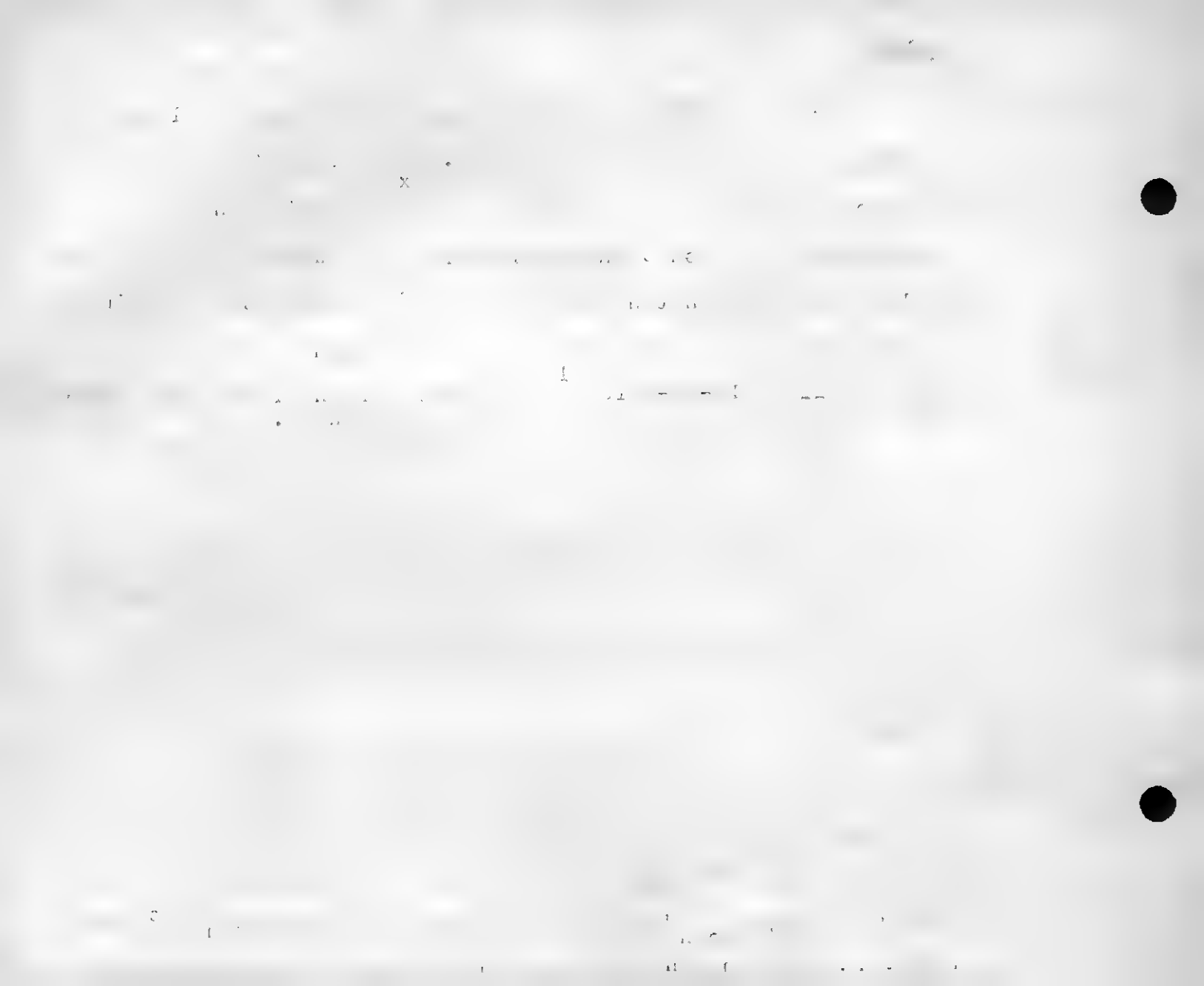
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04609 CERTIFICATE OF DEATH 04602									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR Noon
CHARLES PRESTON RIDENOUR						March 10 1969			12 M
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 FUNDING YEAR MONTHS DAYS HOURS M.N.	
Male	White		October 17 1899			69 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Washington		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash County Hospital			Engineer		U.S. Navy	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Washington			Hagerstown		652 No Prospect St	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Charles W. Ridenour			Mary Kriner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
Yes W. #1 & #2			215-14-0508			Mrs Eva M. Ridenour 652 No Prospect St Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>									3 1/2 mos.
1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>bronchogenic carcinoma</u>									7 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Interpleurisy, General</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>68</u> to <u>3/10</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Arthur K. Riebo</u>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>Arthur K. Riebo</u>		<u>119 E. Chestnut</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/12/69		Long Meadows Cemetery		Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Andrew K. Coffman		Funeral Home Inc		MAR 13 1969		<u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04610 CERTIFICATE OF DEATH 04603									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b HOUR
RAE			(NMN) RUBEN			March 23 1969			2 A. M.
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		Sept. 20 1893			75 YRS		IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland		USA		Washington			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash County Hospital			Housework			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Washington			Hagerstown			51 West Franklin St
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Max Ruben			Lena Simon						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
No			216-46-7813			Mrs Maxwell Greenwald 922 The Terrace			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF STOMACH								2+ yrs.	
1553 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Atherosclerosis Heart Disease & Congestive Failure - Pneumonia.									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 18 Jan. 1969, to 23 March 1969, that (I) (we) last saw the deceased alive on 22 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE					W.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS		24 March 1969		
W.N. FENDER					218 N. Potomac St. Hagerstown, Md				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial		3/25/69		B'Nai Abraham Cemetery			Hagerstown Wash Co Md		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Andrew K. Coffman Funeral Home Inc				MAR 26 1969			J. Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04611

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04604

1. DECEASED-NAME (Type or print) <b>Carl Thurston Shank</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 25, 1905</b>		6. AGE (In years lost birthday) <b>63</b> YRS.		7. UNDER 1 YEAR MONTHS <b>63</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Big Pool, Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b> Md.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tool Maker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Pangborn Co.</b>		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Samuel H. Shank</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ada # Grimes</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war and dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>217-03-5554</b>		
17. INFORMANT <b>Mrs Ethel Shank Hagerstown, Md.</b>			17. ADDRESS <b>123 N. Cannon Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>4104</b> DUE TO, OR AS A CONSEQUENCE OF Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 days</b> <b>yrs</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma of sigmoid colon</b>											
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>none</b>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>none</b> 19 <b>69</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>-</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>none</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>- - - - -</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 7, 1969</b> , to <b>Mar 4, 1969</b> , that (I) (we) lost the deceased alive on <b>Mar 4, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harold R. Tritch, Jr MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>3/5/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Harold R. Tritch, Jr MD</b>						22e. ADDRESS <b>302 N. Potomac St Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/7/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Shanktown Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Big Pool, Md. Wash. Md.</b>		
24. FUNERAL DIRECTOR <b>Margaret Rowland</b>			25a. REC'D BY REGISTRAR <b>Clear Spring, Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. DATE <b>MAR 11 1969</b>		



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

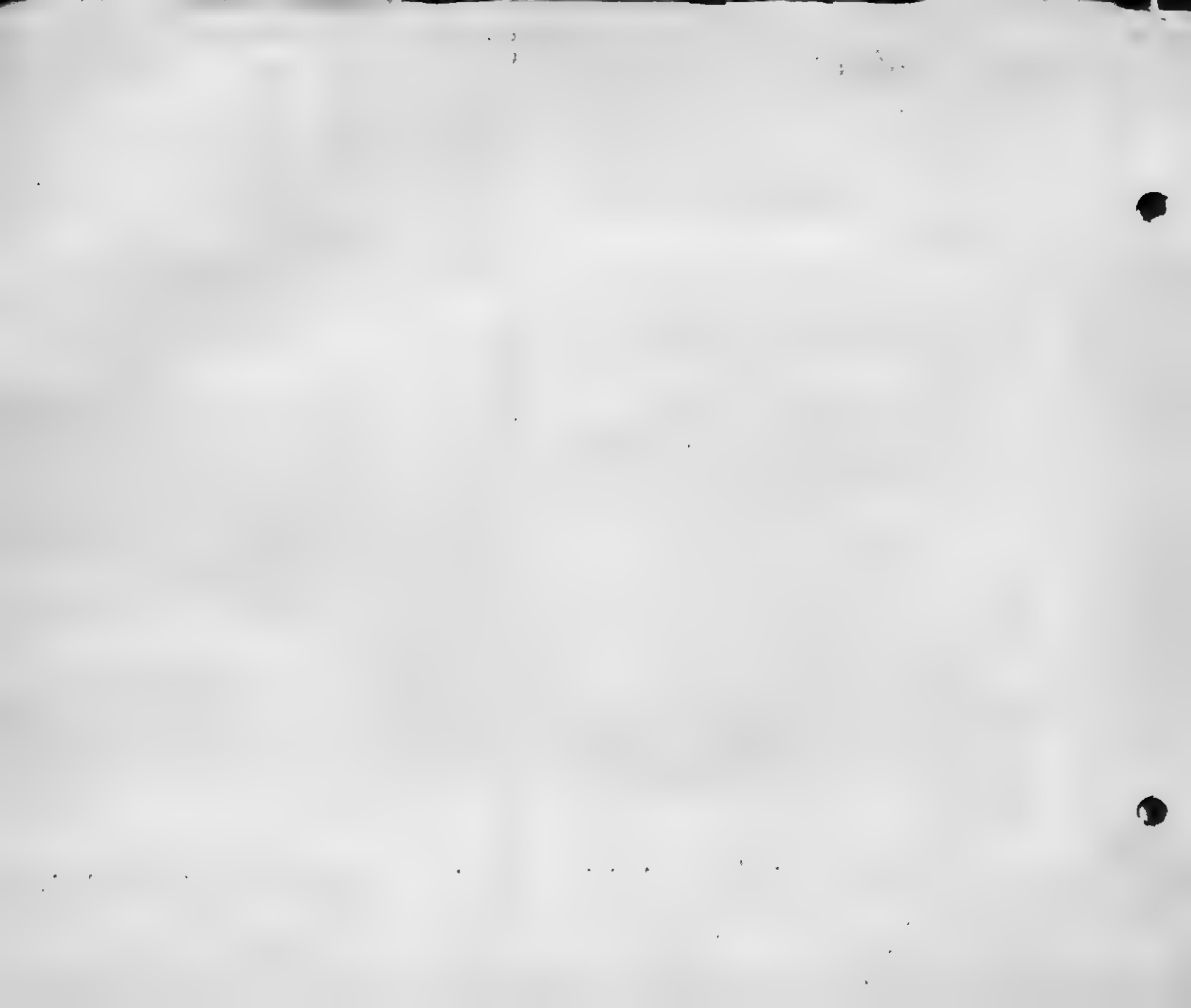
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 371 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

04612

04605

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u> <u>MAUGANSVILLE</u> c. LENGTH OF STAY IN <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RURAL</u> <u>RD 6 HAGERSTOWN</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> d. STREET ADDRESS <u>MAUGANSVILLE</u> <u>RD 6 HAGERSTOWN</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES P SHINDLE</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>NOV. 14 - 1890</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		<b>4. DATE OF DEATH</b> <u>Nov 3 1969</u> Month Day Year	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FAIRCHILD AIRCRAFT CORP</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>		<b>13. FATHER'S NAME</b> <u>JACOB R SHINDLE</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>SUSAN RICE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>214-09-7886</u> <b>17. INFORMANT</b> <u>Mrs Cora M Shindle</u> Address <u>Hagerstown Md</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid Leukemia, chr. and</u> 7145-1 DUE TO Conditions, if any which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>Bilateral lobular pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Colloid goiter, large</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>Jan 1, 1965</u> to <u>Mar 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 19, 1969</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Edward W. Ditto</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>EDWARD W. DITTO, 111, M.D.</u>		<b>22b. DATE SIGNED</b> <u>3-3-69</u> <b>22d. ADDRESS</b> <u>217 W. WASHINGTON STREET, HAGERSTOWN, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u> <b>23b. DATE THEREOF</b> <u>MAY 7 1969</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Beautiful View</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>STATE LINE Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Greencastle PA</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Williamas Judge</u> <b>DATE</b> <u>MAR 5 1969</u>	

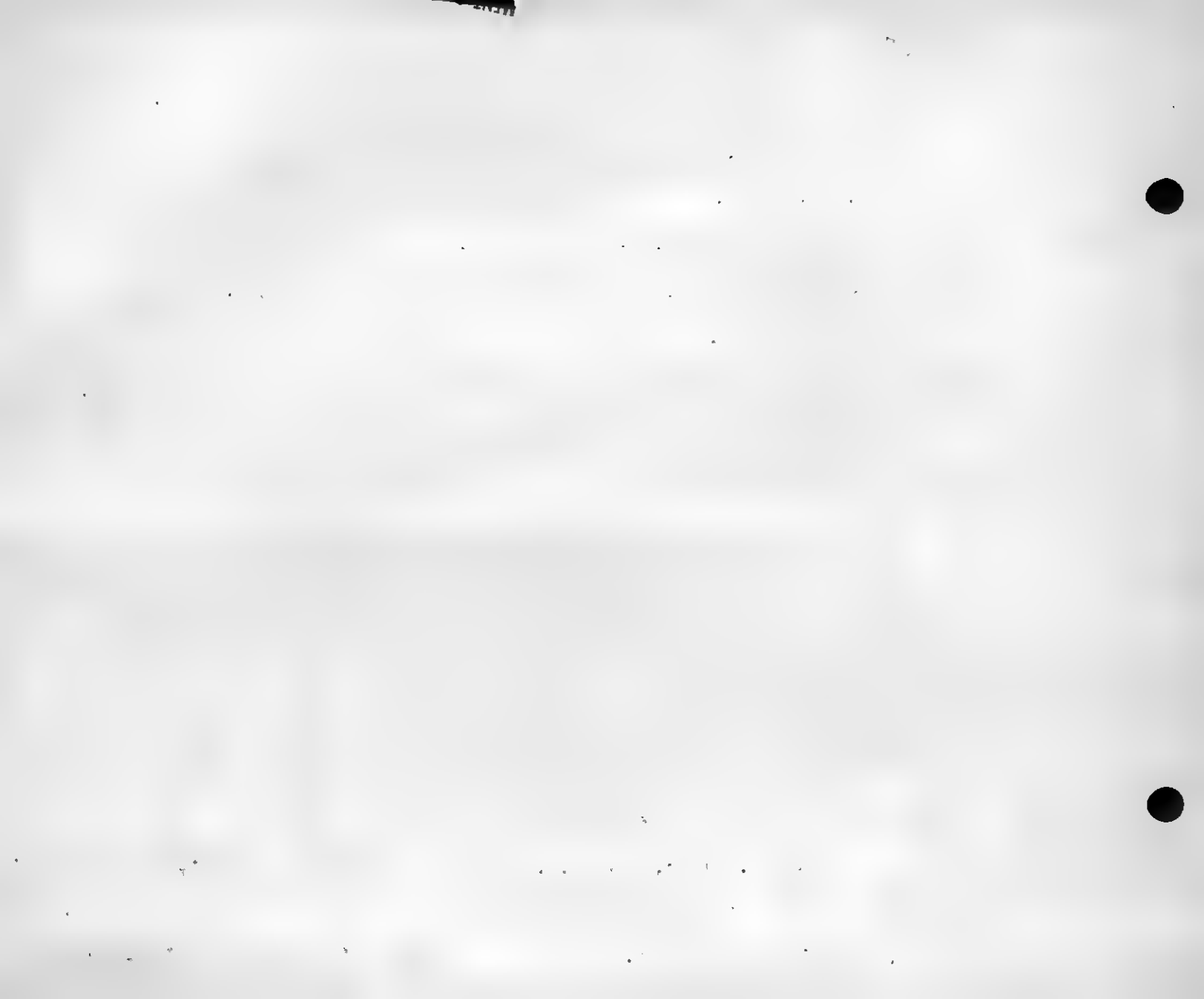


# FOIL STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>2a Film 413</div> <div>2b DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>04613</div> <div>04606</div> </div>															
<b>1. DECEASED-NAME</b> (Type or Print) <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>Albertus</div> <div>I saiah</div> <div>Shipley</div> </div>						<b>2a DATE KNOWN OF DEATH</b> <div> <div>KNOWN</div> <div>ESTIMATED</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>March</div> <div>29</div> <div>1969</div> </div>		<b>2b HOUR</b> <div> <div>8</div> <div>10</div> <div>PM</div> </div>							
<b>3 SEX</b> Male		<b>4 RACE</b> White		<b>5 DATE OF BIRTH</b> Oct. 15 1916		<b>6 AGE</b> (in years last birthday) 52 YRS <div> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS</div> </div> <div> <div>MONTHS</div> <div>DAYS</div> <div>HOURS</div> <div>MIN</div> </div>		<b>7c DATE PRONOUNCED DEAD</b> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>March</div> <div>29</div> <div>1969</div> </div>		<b>7d HOUR</b> <div> <div>9</div> <div>15</div> <div>PM</div> </div>					
<b>7a BIRTHPLACE</b> (State or foreign country) Wash. Co. Md.			<b>7b CITIZEN OF WHAT COUNTRY?</b> U.S.A.			<b>8 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>9 COUNTY OF DEATH</b> Washington						
<b>10 CITY OR TOWN OF DEATH</b> Williamsport				<b>11 NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital give street address) 153 Conococheague St.				<b>12a USUAL OCCUPATION</b> (Kind of work done during most of working life, even if retired) Laborer				<b>12b KIND OF BUSINESS OR INDUSTRY</b> Metal Plating Co.			
<b>13a USUAL RESIDENCE</b> (Where deceased lived, if institution admission) STATE Md.				<b>13b COUNTY</b> Washington				<b>13c CITY OR TOWN</b> Williamsport				<b>13d INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>13e STREET AND NUMBER</b> 153 N. Conococheague St.	
<b>14 FATHER'S NAME</b> <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>John</div> <div>W.</div> <div>Shipley</div> </div>						<b>15 MOTHER'S MAIDEN NAME</b> <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>Edna</div> <div>Mae</div> <div>Shipwe</div> </div>									
<b>16a WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, or unknown) <input checked="" type="checkbox"/> World War 2				<b>16b SOCIAL SECURITY NO</b> 220-05-6384				<b>17 INFORMANT</b> Mrs. Dolores Shipley Williamsport, Md.							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Aspiration</div> <div>Pharyngeal of vomitus</div> <div>3001</div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div> <div>(b)</div> <div>Ac. alcoholic intoxication</div> <div>(c)</div> </div> </div> <div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div> </div>												<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> Immed.			
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>															
<b>19a. DATE OF OPERATION</b>						<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>						<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING</b> <input type="checkbox"/>				<b>21b TIME OF INJURY</b> Month, Day Year P.M. 19				<b>21c HOW INJURY OCCURRED</b> (Enter nature of injury in Part 1 or Part 2, Item 18)							
<b>21d INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				<b>21e PLACE OF INJURY</b> (At home, farm, street, factory, office building, etc.)				<b>21f LOCATION</b> Street or R.F.D. No City or Town County State							
<b>22a I certify that I took charge of the remains described above, held an</b> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <div> <div>Edward W. Ditto, III</div> <div>M.D.</div> </div>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>22b. DATE SIGNED</b> 3-31-69			
<b>EXAMINER'S NAME</b> (Type) EDWARD W. DITTO, III, M.D.						<b>ADDRESS</b> (Street, city, town, or county) 217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND									
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> Burial				<b>23b DATE</b> April 1-69		<b>23c NAME OF CEMETERY OR CREMATORY</b> Cedar Lawn Memorial Park				<b>23d LOCATION</b> (City or Town) (County) (State) Hagerstown Wash. Md.					
<b>24 FUNERAL DIRECTOR</b> Albert L. Leaf Williamsport Md.						<b>ADDRESS</b>		<b>25a REC'D BY REGISTRAR</b> APR 3 1969		<b>25b REGISTRAR'S SIGNATURE</b> Charles Judge					

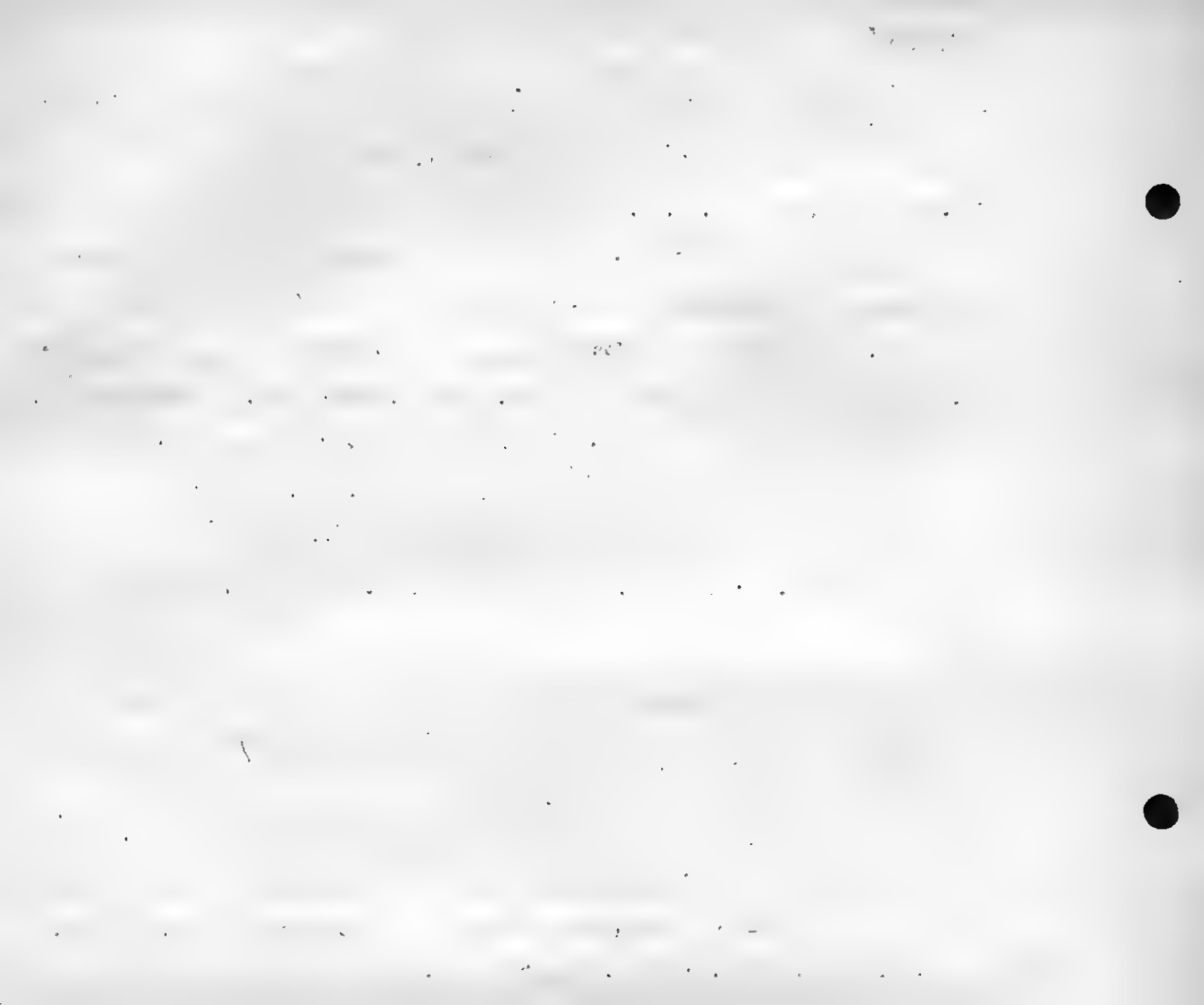


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 11-54  
30M REV. 1-59

04614		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04607	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Hazel Frances Smith</i>			2a. DATE OF DEATH Month <i>Mar</i> Day <i>9</i> Year <i>1989</i>		2b. HOUR <i>4:55 AM</i>		
3. SEX <i>F</i>		4. RACE <i>Wh</i>		5. DATE OF BIRTH <i>May 31, 1907</i>		6. AGE (In years last birthday) <i>61</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Clevelandville, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>WASHINGTON</i> Md	
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Boonsboro</i>		13d. INSIDE CITY LIM. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Rfd. 2</i>		14. FATHER'S NAME First Middle Last <i>J. Ezra Moser</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Carrie House</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mr. Harry E. Smith, Rfd. 2, Boonsboro, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Confluent lobular pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5d</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of endometrium</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>with metastases</i> <i>1yr</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>nephrosclerosis, mitral stenosis, recent endocarditis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-5</i> , 1969, to <i>3-8</i> , 1969, that (II) (we) last saw the deceased alive on <i>3-8</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edwin G. Riley MD</i>		22c. DATE SIGNED <i>3-9-69</i>		22d. PHYSICIAN'S NAME (Type) <i>Edwin G. Riley</i>			
22e. ADDRESS <i>1500 Penna, Hagerstown, Md</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-12-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Boonsboro Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Boonsboro, Wash. Co., Md.</i>		24. FUNERAL DIRECTOR <i>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</i>		25a. REC'D BY REGISTRAR <i>John H. Bast, Jr.</i>		25b. REGISTRAR'S SIGNATURE <i>John H. Bast, Jr.</i>	





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Item 18-111-410 3-13-69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>CERTIFICATE OF DEATH</b>												
1 DECEASED NAME (Type or print) <b>Lillian Irene Smith</b>					2a. DATE OF DEATH <b>3</b> Month <b>7</b> Day <b>69</b> Year					2b. HOUR <b>8.10</b> M		
3. SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>9-4-1897</b>			6 AGE (In years last birthday) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.						
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospitl.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>220 Creek Road</b>			
14 FATHER'S NAME First Middle Last <b>Charles Semler</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Catherine Strock</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address <b>James F. Smith Hagerstown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Tuberculous/Pneumonia Bronchiolar carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF <b>with superimposed pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unknown duration</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Atherosclerosis, Generalized</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>March 4</b> , 19 <b>69</b> , to <b>March 7</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>March 7 1969</b>					
22d. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>					22e. ADDRESS <b>301 E. Antietam Street, Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE <b>3-10-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAR 10 1969</b>		25b. REGISTRAR'S SIGNATURE 					



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04616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04609

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Goldie		P.		Snyder	March 4, 1969		8:00A M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		Feb. 17, 1893		76 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CIT ZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Fairview, Md.	U. S. A.				Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington Co. Hospital		Housewife		Own Home		
13a. USUAL RES DENCE (Where deceased lived, f institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Washington		Hagerstown				1509 Virginia Ave.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William		Strite		Ditto	Margaret			Graham
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECUR TY NO.		17. INFORMANT		Address		
No.		217-09-9907		Mr. Lee G. Snyder,		Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u>								1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic (coronary) HA. Disease</u>								Several years
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>11-29, 1968</u> , to <u>12-24, 1968</u> , that (I) (we) last saw the deceased alive on <u>12-24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John H. Hornbaker, M.D.</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-5-69</u>	
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker, M. D.					22e. ADDRESS 154 W. Washington St., Hagerstown, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3-7-69		Salem Reformed Cemetery		Cearfoss, Wash. Co., Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				ADDRESS		25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>



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04617

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

04610

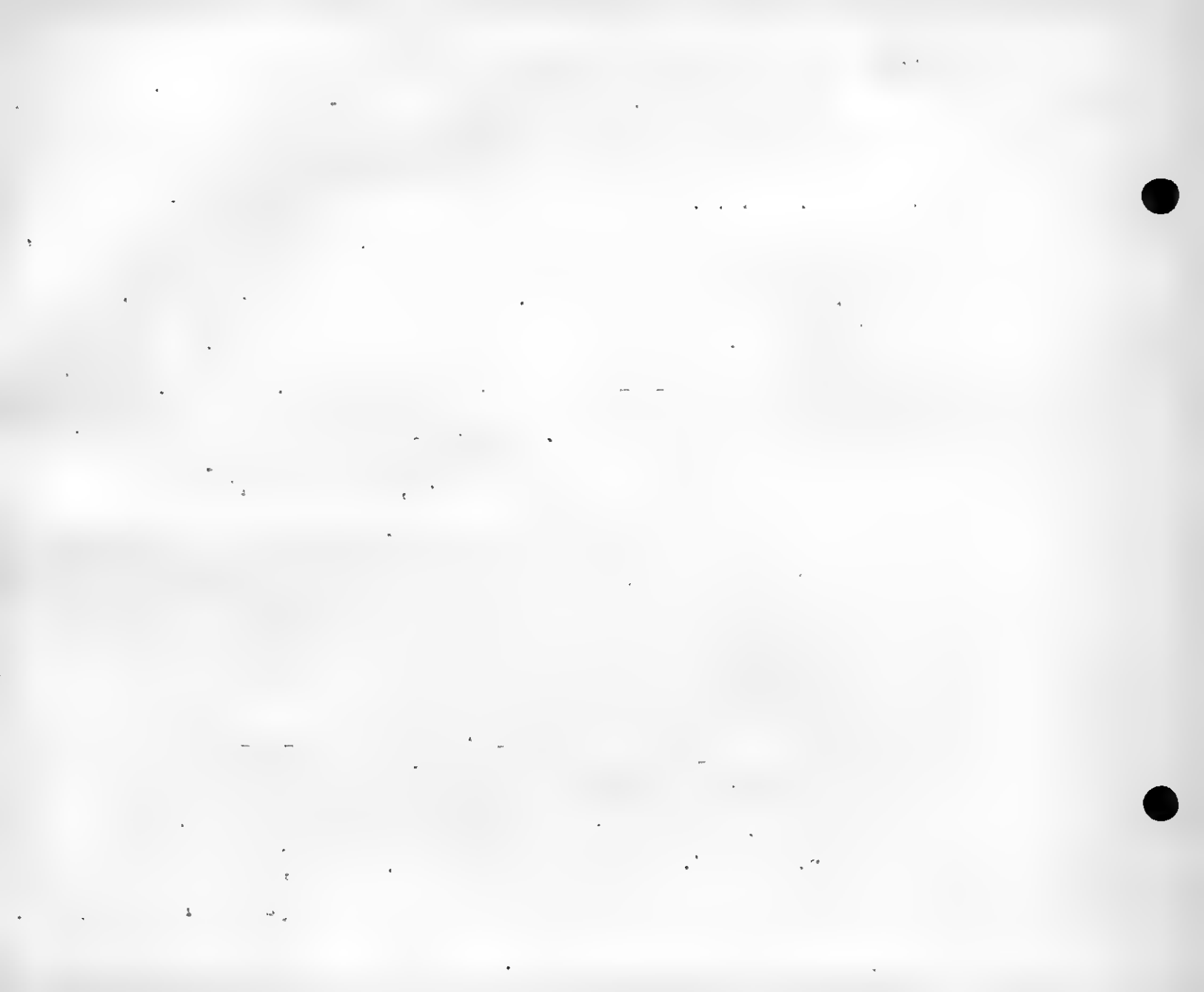
1 DECEASED NAME (Type or print) First Middle Last JOSEPH CHRISTIAN SNYDER			2a. DATE OF DEATH Month Day Year MARCH 2 69			2b. HOUR 5:30p M					
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH JANUARY 19, 1886		6. AGE (in years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON Md					
10 CITY OR TOWN OF DEATH HA ERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 525 N LOCUST STREET			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AUCTIONEER			12b. KIND OF BUSINESS OR INDUSTRY CALLED SALES		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HA ERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 525 N LOCUST STREET		
14. FATHER'S NAME First Middle Last JOHN SNYDER			15. MOTHER'S MAIDEN NAME First Middle Last MARTHA MAZES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16b SOCIAL SECURITY NO 218-30-9588		17 INFORMANT THEODORE R SNYDER, CLEAR SPRING, MARYLAND						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral Cerebral pneumonia</u> 7-2-69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced gen'l arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs 1-2 yrs 25 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Benign Prostate hypertrophy</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1967</u> , to <u>Mar 2, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward W. Ditto</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/3/69			
22d. PHYSICIAN'S NAME (Type) E. W. DITTO, III, M.D.			22e. ADDRESS 215 W WASHINGTON ST., HA ERSTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3/5/69		23c. NAME OF CEMETERY OR CREMATORY ST PAUL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) #2, HA ERSTOWN, WASHINGTON, MD.				
24. FUNERAL DIRECTOR <u>Edm Reizer</u>			HA ERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

THEODORE R SNYDER, CLEAR SPRING, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04618 CERTIFICATE OF DEATH 04611										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Frank			L.		Stull		March		Month 12 Day 1969 Year 7:15P	
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)	
Male			White			May 12, 1892			76 YRS.	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Waynesboro Pa.			U.S.A.						Washington Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown #6			Avalon Manor Nursing Home			Machinist			Landis Machine Co.	
13a. USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Pa.			Franklin			Waynesboro			15 S. Grant St.	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Frisby			C.		Stull				Emma K. Koontz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			Address	
No			173-03-0821A			Mrs. Lois Muir, 15 S. Grant St.,			Waynesboro Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary insufficiency										2 months
1621 DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic carcinoma, lt. lung with										6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) mediastinal metastasis.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Pulmonary emphysema										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
none						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-27, 1969, to 2-12-1969, that (I) (we) lost saw the deceased alive on 2-12-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE			22c. DATE SIGNED							
Dr. John H. Kehne			3/14/69							
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS							
			1229 Ravenwood Heights Hagerstown, Maryland							
23a. BURIAL, CREMATON, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			3/15/69			Cedar Hill			Greencastle, Franklin Pa.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
David G. Love			Waynesboro Pa.			DATE MAR 18 1969			J. C. Jones	



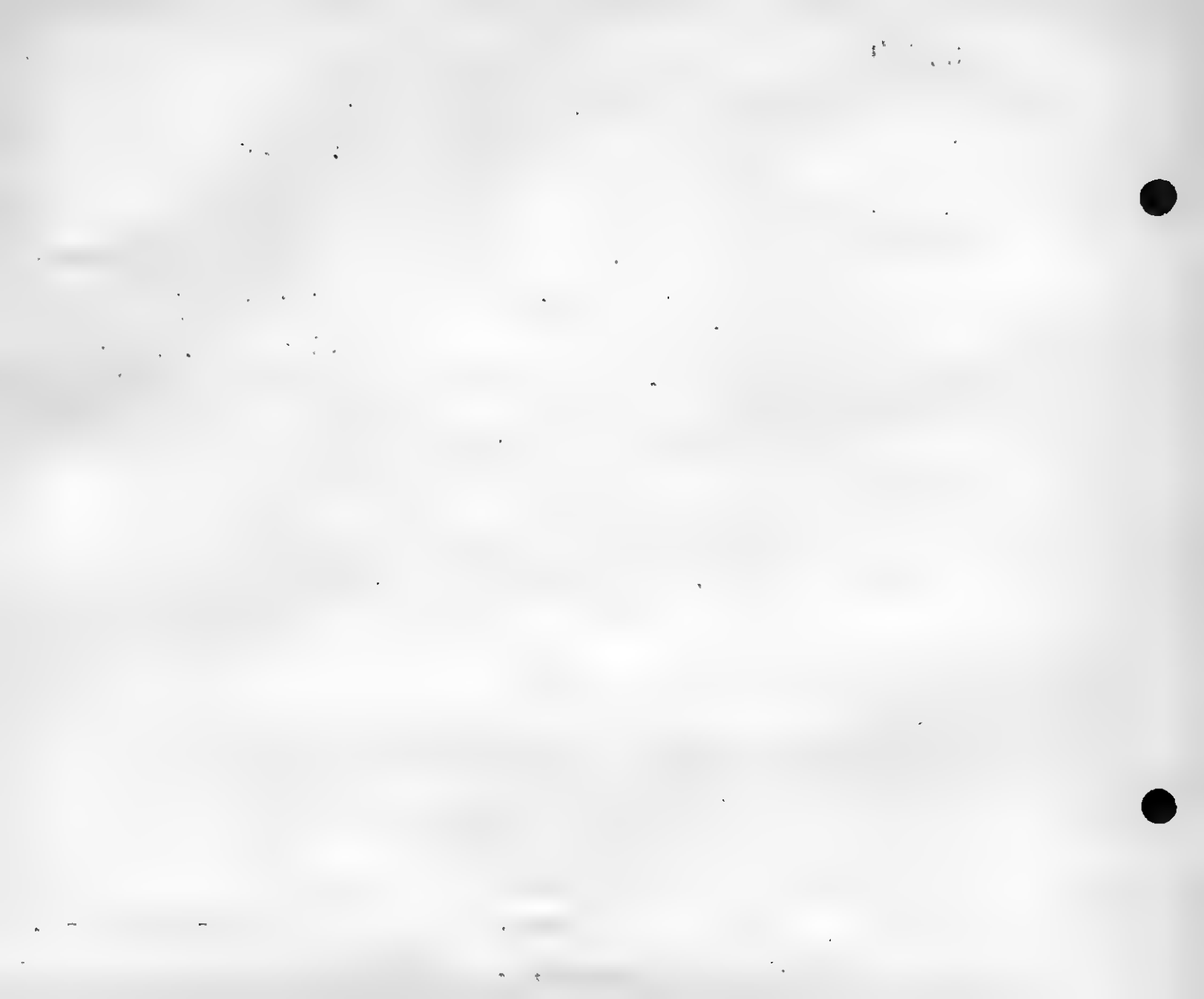


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-104  
30M REV. 1-64

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR
MARY		Edna		Stumbaugh		March		Month 21 Day 69 Year		7:55 PM
3 SEX		4-RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE		white		2-10-1891		78 YRS		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Pennsylvania		U.S.				WASHINGTON				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
HAGERSTOWN		WESTERN MD. STATE HOSPITAL		Hagerstown		Own Home				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		10 Mountain View Circle		
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Franklin		Herce		YEAGER		MARGARET E. Bush				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
No				None		Mrs. Genevieve Beck		108 S. 4th St. Hagerstown, Md.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Esophageal Hemorrhage; Terminal										
5719 DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of the Liver										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Marked Bronchopneumonia bilateral due to Carcinomatosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from January 30 1969 to March 21, 1969, that (I) (we) last saw the deceased alive on March 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
J. U. Porciuncella M.D.		March 22, 1969		J. U. Porciuncella		Western Maryland State Hospital				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/25/69		Rest Haven Cemetery		Hagerstown-Washington Md.				
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
Wm. C. Fort		MAR 26 1969		J. L. Jones						
Rest Haven Funeral Chapel		Hagerstown, Md.								



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

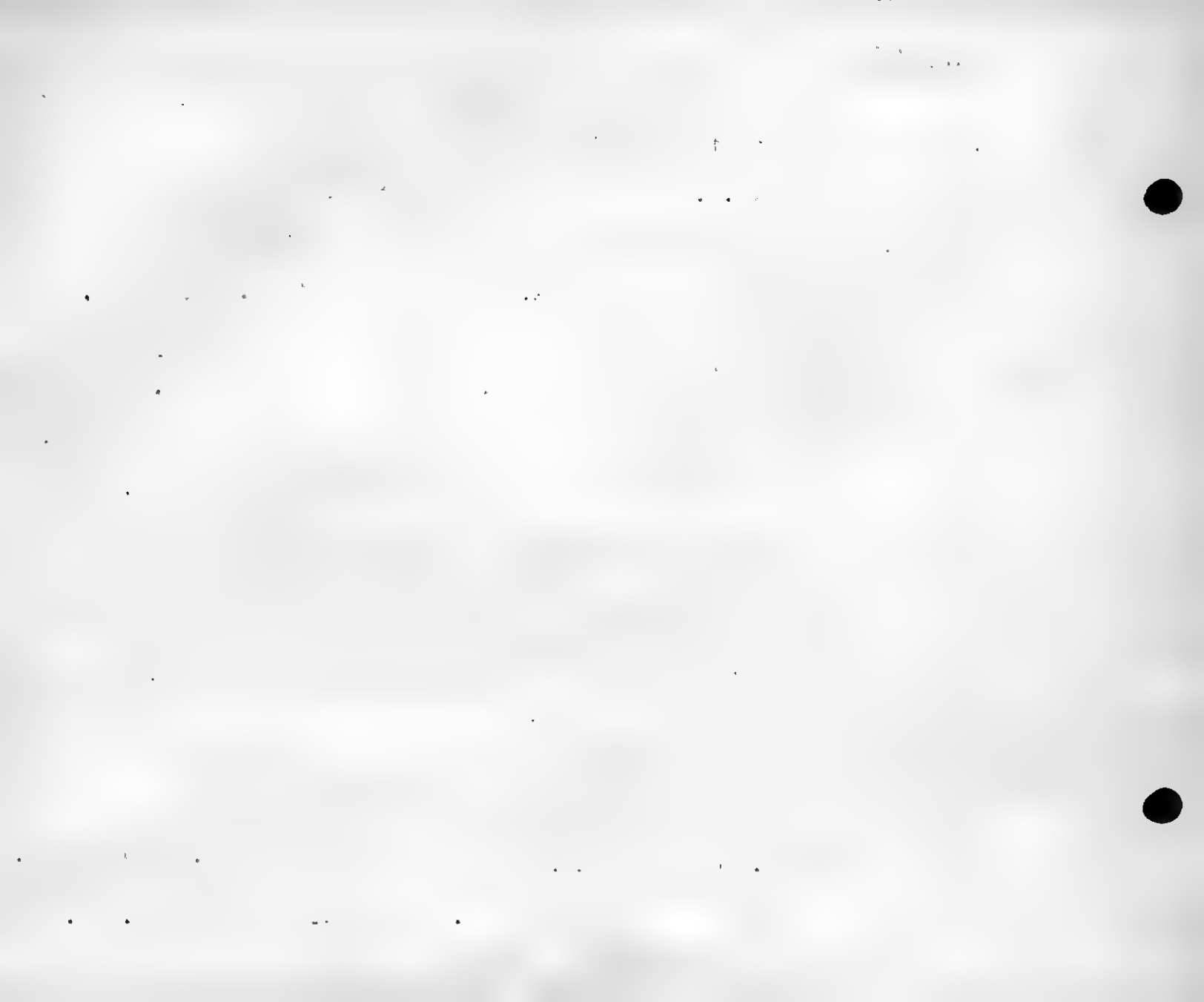
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04620

04613

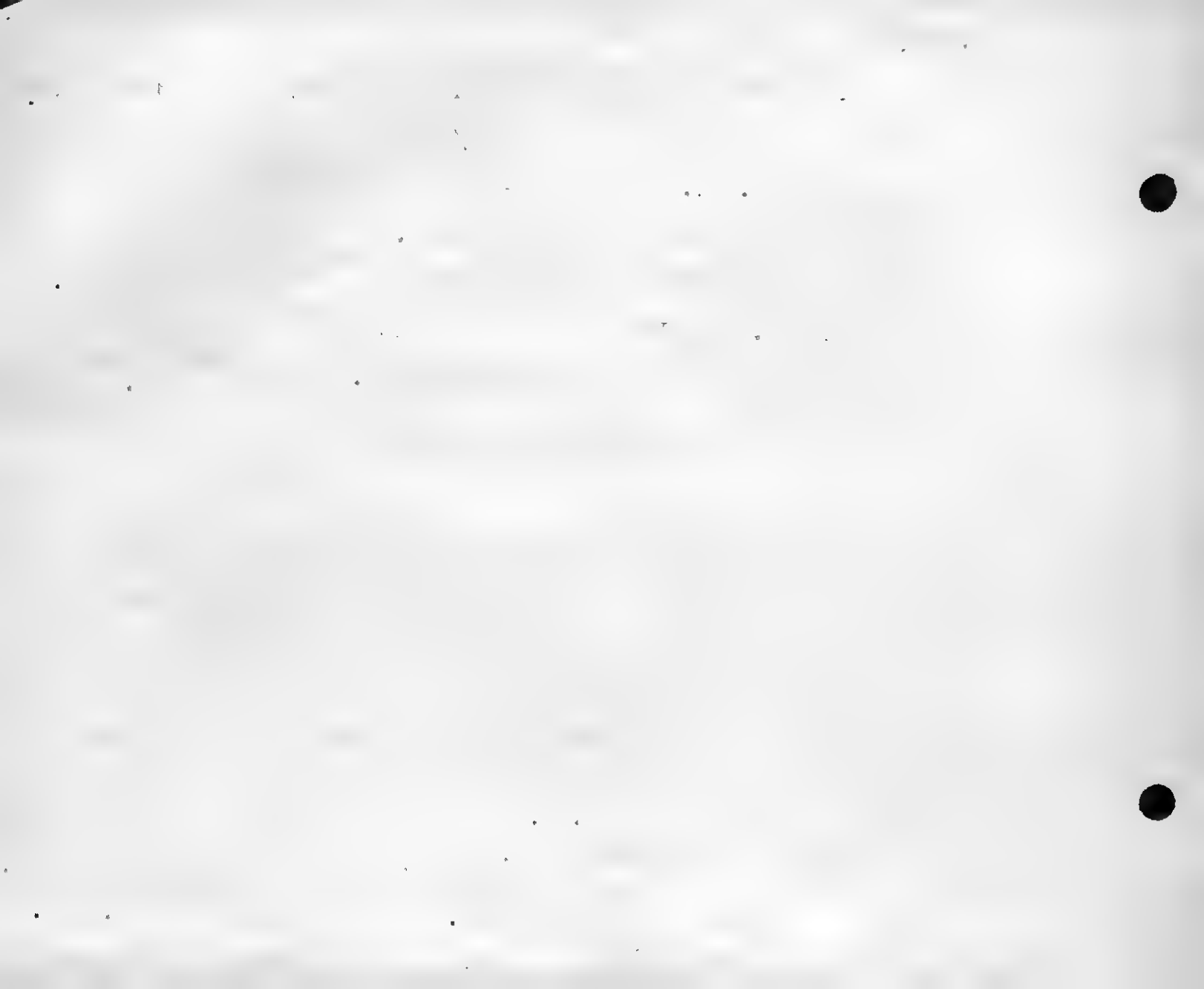
1 DECEASED NAME (Type or Print)		First MIDDLE Last		2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR	
HELEN		MARIE		SUMMERS		MARCH 17 1969		2:15 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years months days)	7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
FEMALE	WHITE	12/14/1898	70 YRS	MONTHS DAYS		HOURS MIN		3 17 1969 2:15 PM	
7a BIRTHPLACE (State or foreign)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				WASHINGTON			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital)		12a USUAL OCCUPATION (Kind of work done during life and during last illness if retired)		12b KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON CO. HOSPITAL		HOUSEWIFE		HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before death)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MARYLAND		WASHINGTON HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13 N. LOCUST ST.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT	
SAMUEL MELVIN SUMMERS		LIDA REYNOLDS		NO		NONE		MRS. MILDRED HOUSER MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Emboli</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Cranio Cerebral Trauma</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>18 1/2 days</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		5:30 PM 2-22-69		Struck by Auto while X-ing Street					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County State	
		Street		Wash. & Locust St		Hagerstown		WASH. MD	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b DATE SIGNED					
EDWARD W. DITTO, III, M.D.		EDWARD W. DITTO, III, M.D.		3-18-69					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)			
				<input checked="" type="checkbox"/>		217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
BURIAL		3/20/69		ROSE HILL CEM.		HAGERSTOWN WASH. MD.			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
W. J. Normant, Hagerstown, Md.		MAR 24 1969		J. L. O'Leary, Jr.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>04621</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04614</div>									
1 DECEASED NAME (Type or print)			First MARGARET Middle IRENE Last ALICE TAYLOR			2a DATE OF DEATH Month 5 Day 1969		2b HOUR 6:45 PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 9/13/1912		6 AGE (In years last birthday) 56 YRS.		7 IF UNDER YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON			
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CONTY HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY HOME			
13a USUAL RESIDENCE (Where deceased lived, if at institution, residence before admission) MARYLAND		13b COUNCIL WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 721 S. POTOMAC ST.	
14 FATHER'S NAME First EDGAR Middle G. Last HOUSER				15 MOTHER'S MAIDEN NAME First HAZEL Middle HEWETT Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, ( ) No (X) (If yes give war or dates of service) NO				16b SOCIAL SECURITY NO NONE		17 INFORMANT MR. HOWARD R. TAYLOR			
						HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Congenital Aneurysm, Left Vertebral artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		State	
22a I certify that (I) (this hospital) attended the deceased from <u>2-28</u> , 19 <u>69</u> , to <u>3-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Charles C. Spencer</u> M. D.				22c DATE SIGNED 3-7-69		22d PHYSICIAN'S NAME (Type) Charles C. Spencer, M. D.			
22e ADDRESS 145 S. Prospect St Hagerstown, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		3/8/69		ROSE HILL CEM.		HAGERSTOWN WASH. MD.			
24 FUNERAL DIRECTOR <u>W. J. Horne</u>				25a REC'D BY REGISTRAR DATE MAR 10 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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1

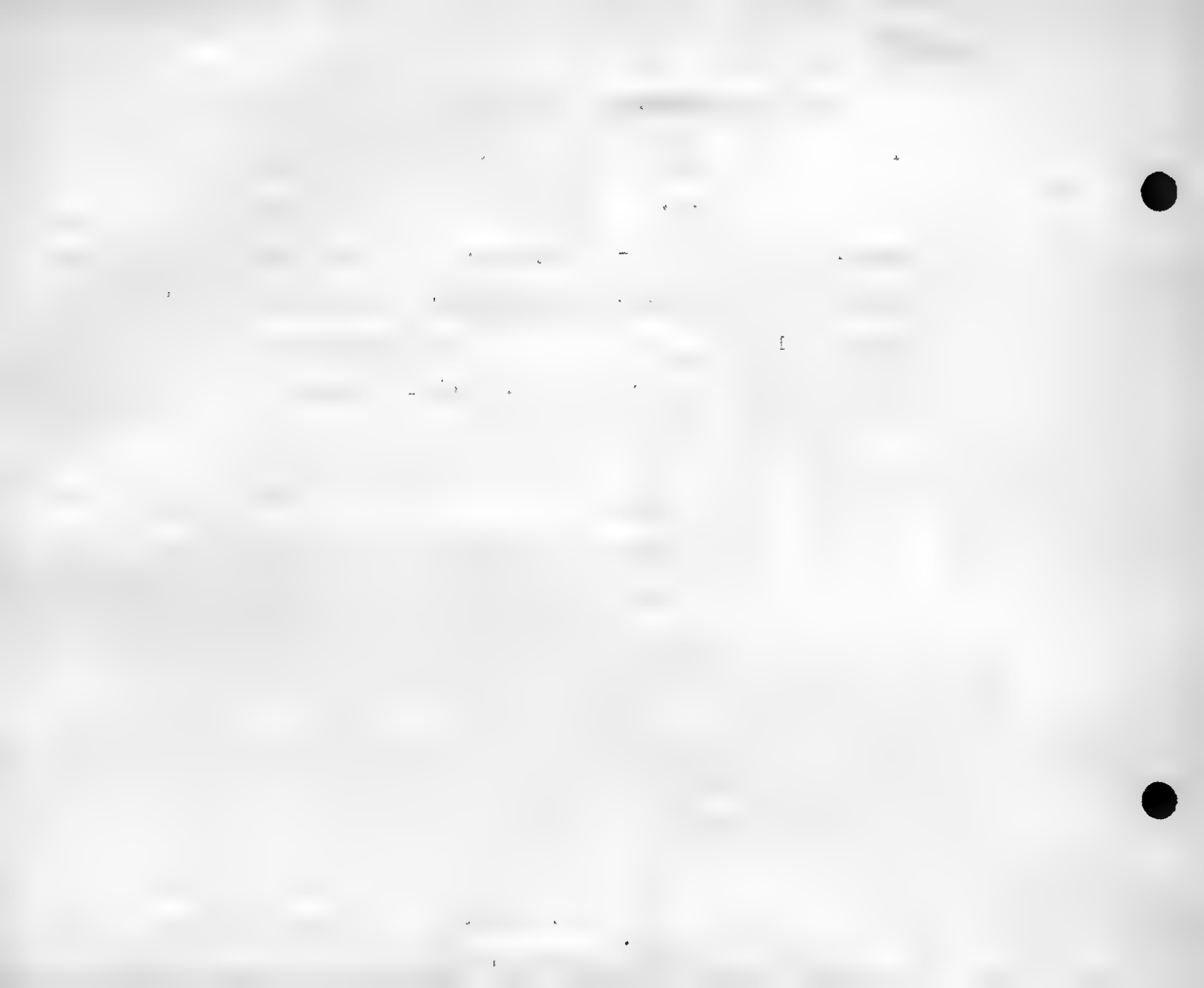
04622

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04615

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
MARY ELIZABETH THOMAS						March 6 1969			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		October 10 1872		96 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Washington		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Boonsboro		Fahrney- Keedy Home		Housewife		Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Washington		Hagerstown				37 East Antietam St			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M A D E N NAME			First	Middle	Last
Thomas H ealey						Katherine Reichard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		J. Richard Thomas							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular</u>								10 yrs			
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) <u>with decompensation</u>			
DUE TO, OR AS A CONSEQUENCE OF								(c) <u>1 1/2 hours</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. no		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 10, 1968</u> to <u>March 6, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		G. W. Heelan M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
								March 7, 1969			
22d. PHYSICIAN'S NAME (Type)		G. W. Heelan M.D.				22e. ADDRESS		Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3/8/69		Rose Hill Cemetery		Hagerstown Wash Co Md					
24. FUNERAL DIRECTOR		Hagerstown Md				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Andrew K. Coffman Funeral Home Inc						MAR 13 1969					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04616			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										04616			
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		2b HOUR		
ROBERT JEREMIAH WAY						MATED <input type="checkbox"/> Mar 27 19			1969		4:50 A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD	
Male		White		July 5 1905		63 YRS						37 277 Year 19 69 5:10 A.M.	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Penna			U.S.A.						Washington				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown				42 East Irvin Ave				Teacher				Retired	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Washington				Hagerstown				42 East Irvin Ave	
14 FATHER'S NAME First Middle Last					15 MOTHER'S M.A.D.E.N. NAME First Middle Last								
A lvin J. Way					Coro Eves								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO					17 INFORMANT ADDRESS			
No					----					42 E. Irvin Ave Mrs Anormallee M. Way			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, sudden</u>										sev. hrs.			
4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										years			
(b) <u>Arteriosclerotic cardiovascular heart disease.</u>													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
None													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
22d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Howard N. Weeks</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b DATE SIGNED			
EXAMINER'S NAME (Type) Howard N. Weeks, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					3/28/69			
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
					ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County)					
Burial			3/29/69		Pine Hall Cemetery			State College Center Co					
24 FUNERAL DIRECTOR Hagerstown Md					ADDRESS					25a REC'D BY REGISTRAR			
Andrew K. Coffman Funeral Home Inc										DATE APR 1 1969			
										25b REGISTRAR'S SIGNATURE			
										<u>William H. Weeks</u>			



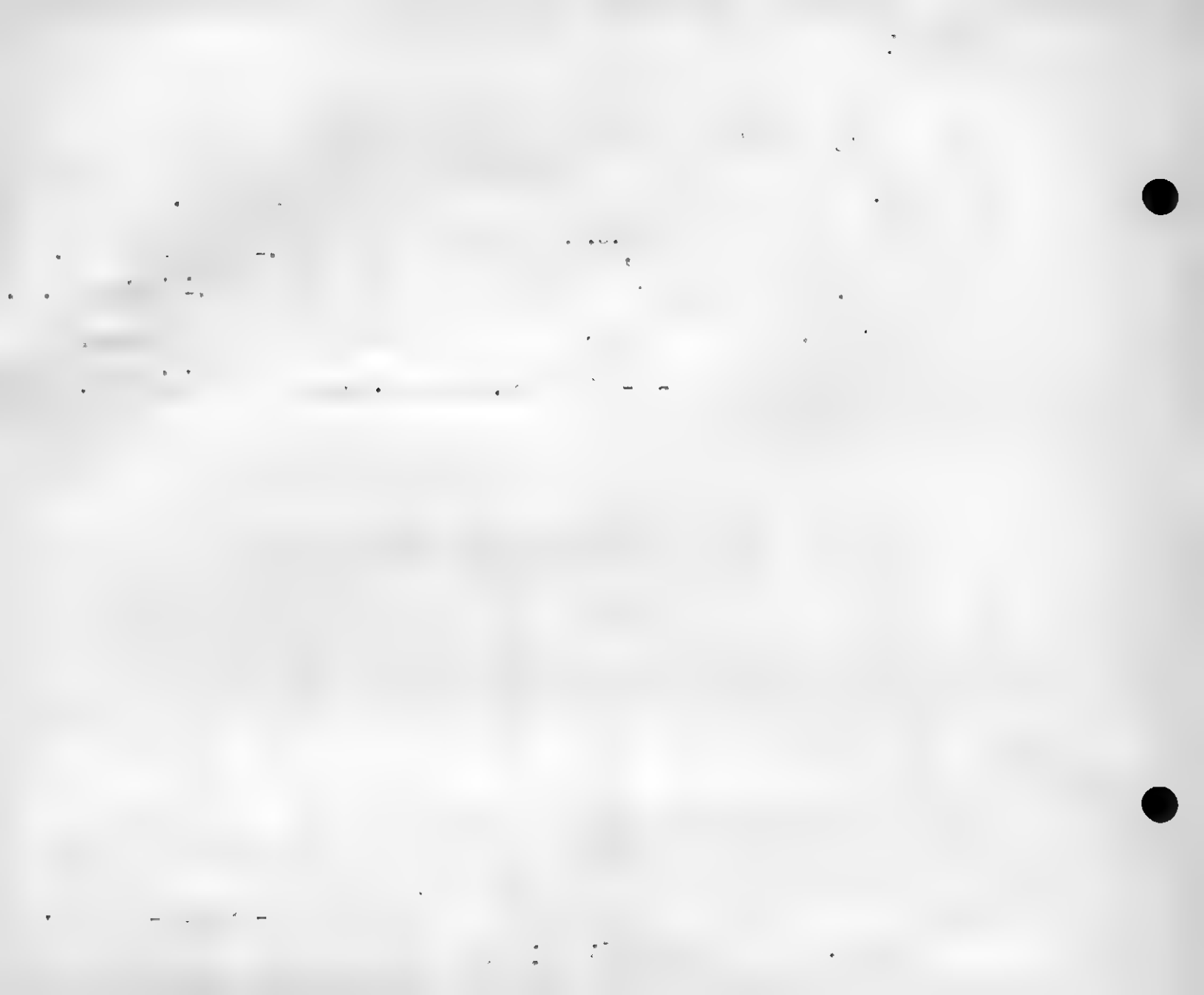
# FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

04624										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04617																													
1. DECEASED-NAME (Type or Print) <b>BRADLEY DOUGLAS WENGER</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>3</b> Day <b>22</b> Year <b>1969</b>										2b. HOUR <b>4:00</b> AM																													
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>11/18/1949</b>			6. AGE (in years last birthday) <b>19</b> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			2c. DATE PRONOUNCED DEAD Month Day Year										2d. HOUR M																					
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>Washington Co.</b> Md.																			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>										11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>D.O.A. Washington Co. Hospital</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Service Dept. Sears Roebuck Co.</b>										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Pa.</b>										13b. COUNTY <b>Franklin</b>										13c. CITY OR TOWN <b>Chambersburg</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER <b>R.R.#8 Greene Twp. Franklin Co. Pa.</b>									
14. FATHER'S NAME First <b>Eliab N.</b> Middle <b>Wenger</b> Last <b>Wenger</b>										15. MOTHER'S MAIDEN NAME First <b>Miriam</b> Middle <b>Elliott</b> Last <b>Wenger</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>										16b. SOCIAL SECURITY NO <b>175-40-3416</b>										17. INFORMANT <b>Mrs. Bradley D. Wenger</b> ADDRESS <b>R.R.#8 Chambersburg Pa. 17201</b>									
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1. DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE (a) <b>ASPIRATION BLOOD &amp; SHOCK</b>																				<b>minutes</b>																													
DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <b>BASAL SKULL FRACTURE, BILAT</b>										<b>SEV HRS</b>																													
DUE TO, OR AS A CONSEQUENCE OF																																																	
(c) <b>FRACTURED FEMURS, CHEST INJURY</b>																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day Year <b>3/22/69</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>AUTO HIT POLE</b>																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>ROAD</b>										21f. LOCATION Street or R.F.D. no City or Town County State <b>Scotland RD Chambersburg Penna.</b>																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE <b>Howard N Weeks</b> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED <b>3/22/69</b>																													
EXAMINER'S NAME (Type) <b>HOWARD N WEEKS</b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
										ADDRESS (Street, city, town or county) <b>HAGERSTOWN MD</b>																																							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>										23b. DATE <b>3/25/1969</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>										23d. LOCATION (City or Town) (County) (State) <b>Chambersburg-Franklin-Penna.</b>																			
24. FUNERAL DIRECTOR <b>Robert G. Sellers</b>										ADDRESS <b>297 Phila. Ave. Chambersburg Pa. 17201</b>										25a. REC'D BY REGISTRAR <b>MAR 24 1969</b>										25b. REGISTRAR'S SIGNATURE																			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04618

04625

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

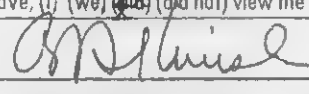
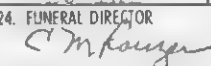

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Frank Clyde Willet					3 27 69					7:48 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
male	white	3-10-47		22 YRS	MONTHS DAYS		HOURS MIN.		SAME 19 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Illinois		USA				Washington		M		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Wash. Co. Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, YET?		13e. STREET AND NUMBER		
Ill.		Cook		Barrington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		202 N. Hager Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Chester Willet					Helen Grassberger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
no				Ruby Willet		Barrington, Ill.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u>										3 days
8199 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Post traumatic lacerations of liver, severe</u>										13 days
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
3/14/69				Intra-abdominal hemorrhage				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		6 HOUR A.M. 3/14 1969		Truck accident						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
		McConnellsburg, Pa.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<u>Howard N. Weeks</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Howard N. Weeks, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3/27/69		
						ADDRESS (Street, city, town, or county)				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
removal		3-27-69				Barrington, Ill.				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG. STR.		25b. REGISTRAR'S SIGNATURE
Minnich Funeral Home				Hagerstown, Md.				APR 1 1969		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT  
304 REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04626											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First MARY			Middle ANN			Last WILLS		
2a. DATE OF DEATH			Month MARCH			Day 5			Year 1969		
2b. HOUR			11:35								
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH JANUARY 8, 1870			6 AGE (In years last birthday) 92 YRS.			7 IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH WASHINGTON Md.				
10 CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COFFEE HOME FOR THE AGED ETHEL STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECS. AF.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. CITY OR TOWN WASHINGTON			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 140 W WASHINGTON ST.		
14 FATHER'S NAME First JACOB			Middle H			Last WILLS			15 MOTHER'S MAIDEN NAME First MARtha		
Middle McCLAIN			Last McCLAIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT M. ANN WILLS		
429			Address N. LOCUST ST.			HAGERSTOWN, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, terminal</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic heart disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1969</u> to <u>March 5, 1969</u> that (I) (we) last saw the deceased alive on <u>March 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED 3/6/69			
22d. PHYSICIAN'S NAME (Type) B. F. W. WISLEY, M.D.		22e. ADDRESS 143 W WASHINGTON ST., HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/7/69		23c. NAME OF CEMETERY OR CREMATORY JOSE HILL CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN, WASHINGTON, MD.		(County)		(State)	
24. FUNERAL DIRECTOR 		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04620					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										04620					
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH			2b HOUR			
Thomas W. Wilson									Month Day Year			24 12 M			
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years or birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR			
male	white	12-13-22		46 YRS	MONTHS DAYS		HOURS MIN		Month Day Year			24 12 M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
Carroll Co		USA		WIDOWED		DIVORCED		Washington							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUA. OCCUPATION (Kind of work done during most of work ng life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown				Washington Co. Hosp.				Laborer				Cement Plan			
13a. USUAL RESIDENCE (Where deceased lived, if instn't an admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.				Fred.		Thurmont		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 Park Lane					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S M.A.DEN. NAME				First Middle Last	
Joseph Wilson										Edna Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
Yes				211-11-6599		Carrie Wilson		2 Park Lane Thurmont							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occipital Skull Fracture + Bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Subdural Hematoma + Laceration of DUE TO, OR AS A CONSEQUENCE OF (c) Cerebellum torn to pieces - cerebral trauma										Approx 24 hr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. COND T DN FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PR MARY OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)									
				2 PM 3-18-1969		Fall down Basement stairs									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		2 Park Lane		Thurmont		Fred.		Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
Edward W. Ditto, III, M.D.								3-20-69							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				217 W. WASHINGTON ST.							
				DEPUTY MEDICAL EXAMINER				HAGERSTOWN, MARYLAND							
ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County) (State)					
Burial		3-22-69		Graceham Cemetery				Graceham		Fred. Co. Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Raymond E. Greager				Thurmont, Md.				MAR 26 1969							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04628 CERTIFICATE OF DEATH 04621									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
JOHN ALTON WINGERT						March 27 1969			2:45 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Dec. 24, 1912		56 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		USA				Washington Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County			Gunsmith			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Penna.			Franklin		Waynesboro			124 West 2nd Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Stover					Wingert	Mary			Ripple
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			184 West 2nd St. Waynesboro, Pa.
No			173-03-1865			Mrs. Elizabeth Wingert			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio. Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>Pulmonary edema</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yes years
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8 Feb 1969 to date, that (I) (we) last saw the deceased alive on 27 Mar 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Richard T. Binford						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 28 Mar. 69	
22d. PHYSICIAN'S NAME (Type) Richard T. Binford M.D.						22e. ADDRESS 1135 Potomac Avenue Hag. Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Mar. 30, 1969		Green Hill Cemetery		Waynesboro, Franklin, Pa.		
24. FUNERAL DIRECTOR S. Martin Boe						25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	
Waynesboro, Pa.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04629		CERTIFICATE OF DEATH						04622			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
Mary Alice Wolfe						March 31 1969			3.20P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Jan. 22, 1894			75 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Mid.	
Middleburg		USA					Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown				909 Corbett St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Calvin Luther Miner			Katherine Lavinia Harbaugh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			214-09-9147B		Frank L. Wolfe			909 Corbett St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastasis to T-11, T-12 and Left 12th Rib</u>										8 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										2 yrs 7 mths certain	
(b) <u>Adenocarcinoma of Hepatic Flexure Colon</u>											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Hypertensive Cardiovascular Disease, Atherosclerotic Heart Disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 18</u> , 19 <u>69</u> , to <u>Mar 31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. T. Layman</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Apr 1 1969</u>		
22d. PHYSICIAN NAME (Type) <u>William T. Layman, M.D.</u>						22e. ADDRESS <u>301 E. Antietam St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>			<u>4/3/69</u>		<u>Rest Haven Cemetery</u>			<u>Hagerstown-Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Horn</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		
<u>Rest Haven Funeral Chapel Hagerstown, Md.</u>						DATE <u>APR 7 1969</u>					

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Abstract

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Page 11

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 34-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>04630</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04623</div>										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Paul Maxheimer Young						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> 3 22 19 69			9:40 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR
male	white	8-16-1897	71 YRS.					3 Day 22 Year 1969		9:40 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		USA				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			117 Englewood Rd.			owner		Dry Cleaning		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.			Wash.		Hagerstown		117 Englewood Rd.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Young				Mollie Brant						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
			175-03-3784		Mrs. Betty A. Burger Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Howard N. Weeks M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Howard N. Weeks				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3/24/69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Washington Co.		
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		3-25-69		Rest Haven Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Minnich Funeral Home Hagerstown, Md.				MAR 26 1969		[Signature]				

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